S. HRG. 103-227

AMBULANCE COSTS UNDER MEDICARE

Y 4. AP 6/2: S. HRG. 103-227

Ambulance Costs Under Medicare, S.H...

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

SPECIAL HEARING

Printed for the use of the Committee on Appropriations

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AMBULANCE COSTS UNDER MEDICARE

FRIDAY, DECEMBER 16, 1994

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:30 a.m., in room SD–192, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

Present: Senator Harkin.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

STATEMENT OF HON. JUNE GIBBS BROWN, INSPECTOR GENERAL

ACCOMPANIED BY GEORGE GROB, DEPUTY INSPECTOR GENERAL FOR EVALUATION AND INSPECTION

HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF KATHLEEN A. BUTO, ASSOCIATE ADMINISTRATOR FOR POLICY

OPENING REMARKS OF SENATOR TOM HARKIN

Senator HARKIN. The appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies, will come to order. This morning's hearing continues the subcommittee's longstanding efforts to reduce waste and abuse in programs within its oversight responsibilities.

Our first panel will be the Honorable June Gibbs Brown, Inspector General, U.S. Department of Health and Human Services—if you would like to come to the table, Ms. Brown—and Kathleen Buto, the Associate Administrator for Policy for the Health Care Financing Administration. This will be our first panel, and the second panel will be Martin Yenawine, president of the American Ambulance Association.

Since I took over chairmanship of this subcommittee in 1989, we have identified a wide range of wasteful and abusive spending practices throughout the Departments of Labor, Health and Human Services, and Education. And I am pleased to say that we have had some success in saving taxpayers' money where waste was exposed. For example, we cracked down on student loan defaulters, saving millions of dollars and allowing more middle-class students a chance at an affordable college education. We have

stopped the outrage of convicted felons continuing to receive Federal workman's compensation payments while being supported by taxpayers in jail. We have made it more difficult for abusers who have been debarred from participation in Federal grant programs from getting other Federal contracts. We have ended the wasteful practice of Medicare paying for alcohol and lobbying expenses of health corporations. Some 17 wasteful or no longer necessary programs under our jurisdiction have been eliminated, and there have been reductions in absurdly high Medicare payments for transcutaneous electrical nerve stimulator [TENS] units, seat-lift chairs, body jackets, intraocular lenses, and other items.

This morning's hearing will focus on a critical component of our health care system, ambulance services. Quality ambulance services are an essential component of good health care. They can mean the difference between life and death. Coming from a largely rural State like Iowa where many people live long distances from hospitals, I am especially aware of the need for quality ambulance services. In Iowa and around the Nation, we have thousands of dedicated professionals and community volunteers providing these needed services night and day in an honest and very high quality manner.

We have a lot of charts here this morning. It may appear to be a battle of the charts, but I think they are all complementary.

As the chart to my far right indicates, starting with "Total ambulance costs under Medicare part B," we see that they have skyrocketed just in the past 6 years. Ambulance claims for Medicare beneficiaries have more than tripled, from $566 million in 1988 to an estimated $1.7 billion this year. That is an average rate of growth of 33 percent a year. Now, while some of this may have been needed to provide access to emergency care in underserved areas, I just cannot believe that anything warrants that kind of a growth rate of 33 percent per year.

Simply put, the American taxpayer is being taken for a very expensive ride. They will lose over $500 million to waste and abuse in the next 5 years unless corrective action is taken and taken soon. There are a number of factors contributing to this huge loss. First, Medicare rules condone, even encourage ambulance companies billing for more expensive ambulance services than are needed. Medicare pays nearly twice as much for advanced life support, ALS, ambulance trips as they do for trips by basic life support, BLS. Medicare often pays the ALS rate even if the person did not need it. The level of service provided seldom enters into the Government's decision about how much to pay.

Again, I want to compliment and congratulate the inspector general's office for doing a great job in this. This blatantly wasteful practice was first identified in October 1992 by the inspector general and the Health Care Financing Administration has yet to stop it, and it has been 2 years.

Another major contributor to the waste in Medicare ambulance payments is the great number of unnecessary trips provided by ambulance services. I am sure that the inspector general will talk about that. Medicare's basic method of payment for ambulance services also contributes to significant waste, and we are going to have to get to that. As the second chart over there shows, Medicare

payments to different ambulance companies for the same trip, the same exact trip, varies from $130 to $183, one of them 40 percent more than the other. Again, Medicare just pays the bill, no incentive to economize.

It should be noted that the average taxpayers are not the only ones getting taken for a ride. Senior citizens and the disabled are being ripped off in two ways. First, the monthly Medicare part B premiums paid by those on Medicare are being increased due to skyrocketing ambulance costs. Second, those on Medicare using ambulance services have to pay 20 percent of the cost of every trip. So for many, their cost, if not covered by private supplemental insurance, can be in the thousands of dollars.

So, I look forward to hearing from our distinguished panelists, June Gibbs Brown, Health and Human Services Inspector General, and Kathleen Buto, the Associate Administrator for Policy at HCFA. As I said, their testimony will be followed by Martin Yenawine, president of the American Ambulance Association.

There are some simple changes that can be made. We have got to make them. We cannot continue to put this off. I will be interested in trying to find out from the Health Care Financing Administration why, when this was identified 2 years ago, nothing has been done yet.

I would like to first begin with Inspector General Brown. We welcome you back to the subcommittee. Again, I appreciate the fine work that you are doing down there. Your statement will be made a part of the record in its entirety and please proceed as you so desire.

Total ambulance costs under medicare part B

	Millions
1988	$566
1989	689
1990	880
1991	1,159
1992	1,336
1993	1,522
1994 (estimate)	1,700

Medicare payments to different ambulance companies for same trip

Company:	*Cost per ride*
A	$130
B	150
C	183

Change in annual Medicare savings from ambulance services—Health and Human Services Inspector General estimates

	Millions
Overpayments for ALS/BLS:	
Old estimate (1989)	$15.9
New estimate (1993)	47.1
Overpayments for dialysis transports:	
Old estimate (1991)	44.0
New estimate (1993)	65.7

Five year potential Medicare savings from ambulance services—projections from Health and Human Services Inspector General estimates

	Millions
Overpayments for ALS/BLS	$235.5
Overpayments for dialysis transports	328.5
Total overpayments	564.0

SUMMARY STATEMENT OF HON. JUNE GIBBS BROWN

Ms. BROWN. Good morning, Mr. Chairman. I am June Gibbs Brown, Inspector General for the Department of Health and Human Services, and with me today is George Grob, Deputy Inspector General for evaluation and inspection. I am pleased to be here to discuss the Medicare payments for ambulance services.

We believe that Medicare needs to revise its payment practices to better ensure that payment is made only for services which are medically necessary. These reforms are especially needed for ambulance transports provided to end stage renal disease beneficiaries.

Most ambulance benefits are covered under Medicare part B and have very strict limits. Ambulance transport must be reasonable and medically necessary. No payments may be made in any case in which some means of transportation other than an ambulance could be utilized without endangering the individual's health whether or not such other transportation is actually available. Generally ambulance transport is covered for patients whose condition requires emergency medical attention or whose condition makes it impossible to sit and it requires transfer by stretcher.

Total Medicare carrier allowances for ambulance transportation under Medicare part B were $1.52 billion in 1993 on behalf of over 3 million beneficiaries.

Our work on ambulance payments leads us to two conclusions.

First, many payments for ambulance transports taking Medicare beneficiaries to and from dialysis violate Medicare guidelines and should never have been made.

Second, Medicare has a problem in the way it reimburses for ambulance transports, not just for dialysis patients, but all Medicare beneficiaries. As a result it pays too much.

Let me talk about each of these in turn, first on dialysis transport.

In 1991 Medicare part B covered medical services for over 190,000 end stage renal disease, or [ESRD], beneficiaries. In general, ESRD beneficiaries obtain their dialysis treatments three times a week, often for many years, at hospital-based or freestanding dialysis facilities. These dialysis treatments are scheduled in advance for particular times and days.

ESRD beneficiaries sometimes use ambulances not only for medical emergencies and transport to hospitals, as any other Medicare beneficiary, but also for transportation to hospital-based dialysis facilities and approved freestanding facilities. When ESRD beneficiaries are regularly transported to dialysis by ambulance, costs can mount quickly.

The most recent data available shows that in 1988 Medicare carriers allowed $36 million for ESRD ambulance transportation. By

1991 the total allowed amount had grown to $98 million, and by 1993, allowances had reached $153 million, a fourfold increase in 5 years. This growth is shown in our exhibit 1, the white chart on this side.

Senator HARKIN. Let me just interrupt. That is just for end stage renal dialysis.

Ms. BROWN. That is right. We are talking about just that universe at this time.

Most ESRD patients use little or no ambulance service. A small percentage of ESRD patients amount for the vast majority of Medicare payments for ambulance services on behalf of this population. This distribution is shown on the chart up here.

Senator HARKIN. This one right here.

Ms. BROWN. Yes.

Senator HARKIN. Are you going to explain that chart?

Ms. BROWN. Yes; 2,600 beneficiaries, less than 2 percent of the total, each used over $10,000 in ambulance services over the course of a year and accounted for $76 million in ambulance payments for this population, or just about three-quarters of the total.

Senator HARKIN. And 191,000 beneficiaries only cost $24 million.

Ms. BROWN. That is right.

Senator HARKIN. Can you tell me, Ms. Brown, of those 2,600 beneficiaries and that $76 million, have your investigations shown a certain area of the country that is using this more than others? Are there certain ambulance services that are using this more than others, or is it widespread coast to coast? What is this?

Ms. BROWN. Well, it has become widespread over this period of time, but there are pockets where it is more prevalent and we have some criminal investigations going on in some areas as well.

Senator HARKIN. Could you provide for this committee a breakdown either by city perhaps where the biggest use by beneficiaries of these ambulance services are for those 2,600 beneficiaries?

Ms. BROWN. Yes sir.

Senator HARKIN. Could you provide that for this committee?

Ms. BROWN. I will.

Senator HARKIN. I would like to take a look and see what cities and what services are doing this to us. Do you have that readily available?

Ms. BROWN. It will not take us very long to get that.

Senator HARKIN. I appreciate that.

Ms. BROWN. In fact, only 355 of those beneficiaries, part of that 2,600, or less than one-tenth of 1 percent of the total, ran up allowed ambulance costs of $50,000 or more each, for a total of almost $22 million.

Senator HARKIN. Now, I would like to know where they are located too.

Ms. BROWN. Given the amounts paid out for ESRD beneficiaries using ambulance services, we conducted a further examination to determine whether ambulance transportation to dialysis treatment was medically necessary. We found 70 percent of the dialysis-related ambulance claims we examined did not meet Medicare's coverage guidelines for medical necessity. The middle chart over there portrays that. That is 70 percent in red that did not meet the medical guidelines.

Senator HARKIN. You mean the medical guidelines that HCFA already has.

Ms. BROWN. That is right.

Senator HARKIN. But they went ahead and paid them anyway.

Ms. BROWN. Those were paid. Yes, sir.

These claims represent $44 million improperly paid by Medicare in 1991. Applying the rate of inappropriate payments that we found in 1991 to the increased total of ambulance payments made on behalf of these beneficiaries in 1993, we estimate that improper payments rose to $65.7 million in 1993.

Over the past 5 years, we have had 82 convictions and civil judgments in the ambulance area. Over one-half of the criminal convictions concerned ambulance services for ESRD patients. So prevalent is the ESRD ambulance fraud that a special project, Project Wheels of Fortune, has been established in one of our regions solely to address this issue. Over 25 ambulance companies have been targeted throughout three Federal districts. Each potential target was identified for matching dates of service for dialysis with dates of ambulance transportation. Each ambulance company had submitted claims in excess of $25,000 for ESRD beneficiaries.

Let me give you a couple of examples of our successful cases.

An ambulance company owned by a husband and wife were sentenced to 4 months home detention, fined $10,000, and ordered to make restitution of $169,000 for submitting fraudulent Medicare claims in connection with transporting ESRD patients. Their company transported Medicare patients in a Lincoln Town Car to dialysis centers, but they charged Medicare for emergency ambulance services to a hospital.

In a second case, a Louisiana ambulance company owner pled guilty to charges of falsifying ESRD patients' true medical condition in order to meet the medical necessity requirements for an advanced life support ambulance transportation. The owner was sentenced to 5 years of supervised probation, fined $500,000, ordered to pay restitution in the amount of $250,000 and complete community service equaling $500,000.

In a third case, a Pennsylvania hospital billed Medicare for ESRD patient services for which it was not entitled to reimbursement. The hospital billed as if it had transported patients and provided advanced life support services when in fact basic support services were provided by another company. The hospital agreed to pay $374,430 in civil penalties and restitution.

We have suggested targeted options to HCFA as ways to address the problems discussed here, including publicizing the problems to beneficiaries, ambulance companies, dialysis facilities, and carriers; seeking out effective practices to identify appropriate payments; and conducting targeted post-payment review.

Like many program officials and advocates, we are concerned about how ESRD beneficiaries who do not have a medical need for ambulances will get to their dialysis treatments. Are there other means of transportation available?

To help answer this question, we conducted interviews regarding available transportation in eight cities where patients are being transported by ambulance to dialysis treatment. Dialysis facility respondents in five of the sampled cities thought that there was

enough transportation available for people going to dialysis. Patients use cars, taxis, wheelchair vans, passenger vans, and buses to get to their dialysis treatments.

Financial assistance for transportation expenses comes from a variety of sources. These include Medicaid, State kidney programs, American Kidney Fund, Area Agencies on Aging, the American Red Cross, and the National Kidney Foundation.

However, respondents did identify problems in some locations for some patients. In one of the eight cities, dialysis facility respondents felt there was not enough transportation for all people going to dialysis. In two other cities, respondents did not think there was enough for certain people or in certain areas.

Respondents also identified other barriers to access, and three problems were frequently mentioned: long waiting times, costs for patients not eligible for financial assistance, and lack of physical assistance to patients using the services. HCFA is currently conducting further research in this area.

Now, let me move to a different issue, which is the method of payment for ambulance services in general.

There is a general problem about the way Medicare pays for ambulance service. Medicare does not base its payments on the resource costs, but charges. Ambulance companies are paid based on what they have charged in the past or what other companies in the area charge. Under this system, each ambulance company gets paid a different amount for the same service and payments may have little to do with the actual cost.

An example of this is how Medicare reimburses for different levels of service. Medicare pays more for a claim made for advanced life support, [ALS] transport than a claim made for the basic life support [BLS] transport. An ALS transport contains sophisticated lifesaving equipment and is used when the patient needs to be maintained medically while en route to another destination. It is typically used in emergency situations. A BLS ambulance, on the other hand, does not contain the same level of equipment and is primarily used for transportation of medically stable patients. An ALS ambulance is staffed with paramedics who have more training and are paid more than emergency medical technicians who typically staff the BLS transport.

However, when an ALS ambulance is used to transport a Medicare beneficiary, payment is made at the higher rate regardless of whether ALS services were actually provided.

In 1988 a little more than a quarter of all base charges were for ALS services. By 1993 we are approaching one-half of all base charges being made for ALS services. Exhibit 4, the last one on this side, reflects this growth. We originally estimated $16 million was lost due to policies which allowed payment for the ALS level when it was not needed. That was in 1989. Since then the problem has grown to $47 million in 1993.

We have recommended that HCFA revise its policy to require that payments for nonemergency ambulance service at the ALS level be allowed only when medically necessary. We suggested that HCFA consider the use of physician certification to authenticate the need for the ALS level. We also recommended that HCFA instruct carriers to institute controls to ensure that payments for

ALS services are based on the medical need of the beneficiary and that HCFA should closely monitor compliance.

HCFA has generally concurred with all the recommendations that we have made regarding ambulance services for ESRD beneficiaries as well as the ALS/BLS services. These recommendations are contained in four OIG reports on these subjects, which I am pleased to submit for the record.

For ESRD beneficiaries, HCFA is taking steps to revise the coding system and is engaged in a comprehensive effort to improve overall coverage and payment policies, including those involving nonemergency transports.

While we certainly agree that medically necessary ambulance service for Medicare beneficiaries is an important part of the program, we also believe that ambulance service should be provided to beneficiaries in a cost-effective manner and controls should be in place to minimize the amount of fraud and abuse. The reports I have described today indicate that there are significant shortcomings in the area of ambulance policy, and thus the services provided to Medicare beneficiaries. We are pleased that HCFA has responded positively to our reports.

PREPARED STATEMENT

This concludes my prepared testimony and I will put the written testimony into the record. I would be happy to answer any questions.

[The statement follows:]

STATEMENT OF JUNE GIBBS BROWN

Good morning, Mr. Chairman and members of the subcommittee. I am June Gibbs Brown, Inspector General of the Department of Health and Human Services (HHS). I am pleased to be here today to discuss Medicare payments for ambulance services.

We believe that Medicare needs to revise its payment practices and better ensure that payment is made only for services which are medically necessary. These reforms are especially needed for ambulance transports provided to ESRD beneficiaries.

BACKGROUND

Department of Health and Human Services

The Department of Health and Human Services (HHS) is the Federal Government's principal agency for promoting the health and welfare of Americans and for providing essential services to persons of every age group. The Department's two largest health programs are Medicare and Medicaid, which are administered by the Health Care Financing Administration (HCFA). Medicare part A provides hospital and other institutional insurance for approximately 36 million persons age 65 or older and for certain disabled persons. Part A is financed by the Federal hospital insurance (HI) trust fund, and fiscal year 1994 expenditures are estimated at $101 billion. Medicare part B (supplementary medical insurance, or SMI) is an optional program which covers most of the costs of medically necessary physician and other non-institutional services. Part B is financed by Medicare participants and general revenues, and fiscal year 1994 expenditures are estimated at $57 billion.

Office of Inspector General

Oversight of the Medicare Program is provided by the HHS Office of Inspector General (OIG). Created in 1976, the OIG is statutorily charged with protecting the integrity of departmental programs, as well as promoting their economy, efficiency, and effectiveness. We meet our challenge through a comprehensive program of audits, program evaluations, and investigations. The activities of our office consist of a multi-faceted approach to improving the management of the department and protecting its programs and beneficiaries from fraud, waste, and abuse. Last year, we

generated savings, fines, restitutions, penalties, and receivables of over $8 billion, which represents $80 in savings for each Federal dollar invested in our office, or $6.4 million in savings per OIG employee.

Ambulance transportation

While ambulance benefits may be covered under Medicare part A, we would like to focus our discussion on payments made under Medicare part B by Medicare carriers. Most ambulance benefits are covered under Medicare part B and have very strict limits. Ambulance transport must be reasonable and medically necessary. No payment may be made in any case in which some means of transportation other than an ambulance could be utilized without endangering the individual's health, whether or not such other transportation is actually available. Generally, ambulance transport is covered for patients whose condition requires emergency medical attention, or whose condition makes it impossible to sit and requires transfer by stretcher.

Total Medicare carrier allowances for ambulance transportation under Medicare part B were $1.52 billion in 1993, on behalf of over three million beneficiaries.

Office of Inspector General work on ambulance payments

Our work on ambulance payments leads us to two conclusions.

First, many payments for ambulance transports taking Medicare beneficiaries to and from dialysis violate Medicare guidelines and should never have been made.

Second, Medicare has a problem in the way its reimburses for ambulance transports—not just for dialysis patients but all Medicare beneficiaries. As a result, it pays too much.

Let me talk about each of these in turn.

PAYMENTS FOR DIALYSIS TRANSPORTS BY AMBULANCE

In 1991, Medicare part B covered medical services for over 190,000 end stage renal disease (ESRD) beneficiaries. In general, ESRD beneficiaries obtain their dialysis treatments three times a week, often for many years, at hospital-based or free-standing dialysis facilities. These dialysis treatments are scheduled in advance for particular days and times.

ESRD beneficiaries may use ambulances not only for medical emergencies and transport to hospitals, as may any other Medicare beneficiary, but also for transportation to hospital-based dialysis facilities and approved free-standing facilities. When ESRD beneficiaries are regularly transported to dialysis by ambulance, costs can mount quickly.

Growth of payments.—Payments made by Medicare carriers on behalf of ESRD beneficiaries for ambulance services more than doubled between 1988 and 1991. The most recent data available shows that in 1988, Medicare carriers allowed $36 million for ESRD ambulance transportation; by 1991, the total allowed amount had grown to $98 million; by 1993, allowances had reached $153 million. (This growth is show in exhibit 1.)

Distribution of payments.—Most ESRD patients use little or no ambulance services. A small percentage of ESRD patients account for the vast majority of Medicare payments for ambulance services on behalf of this population. (This distribution of payments is shown in exhibit 2.)

According to the 1991 data collected during the course of our review on this subject:

—Seventy-nine percent of ESRD patients used no ambulance services at all.

—Another 14 percent used less than $500 worth of ambulance services each in the entire year.

—In all, 191,310 ESRD patients (98 percent) used a total of $24 million of ambulance services.

—In contrast, 2,600 beneficiaries—less than 2 percent of the total—each used over $10,000 in ambulance services over the course of the year and accounted for $76 million in ambulance payments for this population, or three-quarters of the total.

—In fact, only 355 beneficiaries, or less than one-tenth of 1 percent of the total, ran up allowed ambulance costs of $50,000 or more each, for a total of almost $22 million.

Given the amounts paid out for ESRD beneficiaries using ambulance services, we conducted a further examination to determine whether ambulance transportion to dialysis treatment was medical necessary.

Appropriateness of payments.—Seventy percent of the dialysis-related ambulance claims we examined did not meet Medicare's coverage guidelines for medical necessity. (Exhibit 3 reflects our findings.)

These claims represent $44 million improperly paid by Medicare in 1991. Applying the rate of inappropriate payments that we found in 1991 to the increased total of ambulance payments made on behalf of these beneficiaries in 1993, we estimate that improper payments rose to $65.7 million in 1993.

We based our determinations of medical necessity on information provided by the dialysis facility's head nurse, information from the patient's treating physician, claims forms, certifications of medical necessity, ambulance trip reports, and medical records usually provided by the dialysis facility. A medical team reviewed all these documents to assess the patient's medical history, diagnosis and ambulatory status.

Claims did not meet Medicare guidelines because on the date of ambulance service beneficiaries did not have conditions that contraindicated the use of another type of transport. Of the claims that were medically necessary, beneficiaries had conditions including, but not limited to, dementia, spinal cord compression, hypotension after dialysis, and severe obesity. We also assessed whether the patient had a medical condition that would make them bed confined, and if not, whether other destabilizing conditions were present that would have necessitated use of an ambulance. In absence of any such indications, we considered the claim to have been inappropriately paid.

All of the inappropriately paid transports were to or from a dialysis treatment. Virtually all (99 percent) were scheduled in advance. Nearly all of the beneficiaries associated with these claims (97 percent) were regularly transported, three days a week.

Fraud.—Over the past 5 years, we have had 82 convictions and civil judgments in the ambulance area. Over half of the criminal convictions concerned ambulance service for ESRD patients.

So prevalent is ESRD ambulance fraud that a special project, "project wheels of fortune," has been established in one of our regions solely to address this issue. Over 25 ambulance companies have been targeted throughout three Federal districts. Each potential target was identified by matching dates of service for dialysis with dates of ambulance transportation. Each ambulance company had submitted claims in excess of $25,000 for ESRD beneficiaries.

The following are some examples of our successful cases:

—An ambulance company owned by a husband and wife were sentenced to 4 months home detention, fined $10,000 and ordered to make restitution of $169,000 for submitting fraudulent Medicare claims in connection with transporting ESRD patients. Their company transported Medicare patients in a Lincoln Town Car to dialysis centers but charged Medicare for emergency ambulance services to a hospital.

—A Louisiana ambulance company owner pled guilty to charges of falsifying ESRD patients' true medical conditions in order to meet the medical necessity requirements for advanced transportation by ambulance. The owner was sentenced to 5 years supervised probation, fined $500,000, ordered to pay restitution in the amount of $250,000 and complete community service equaling $500,000.

—A Pennsylvania hospital billed Medicare for ESRD patient services for which it was not entitled to reimbursement. The hospital billed as if it had transported patients and provided advanced life support services, when in fact basic support service was provided by another company. The hospital agreed to pay $374,430 in civil penalties and restitution.

Recommendations to HCFA.—We have suggested the following targeted options to HCFA as ways to address the problems discussed above. For carriers with very high ambulance allowances, we recommended that HCFA:

—Publicize the problem: alert Medicare carriers that utilization of ambulance service by ESRD beneficiaries is highest for dialysis-related transports, that these claims are for a small number of ESRD beneficiaries, and many of these claims are not medically necessary.

—Publicize the possibilities of identifying the target population: alert Medicare carriers it is possible to identify, in a prospective manner, those ESRD beneficiaries with high potential for large expenditures for ambulance services.

—Seek out effective practices: identify carriers using methods that ensure that transport for ESRD beneficiaries is medically necessary, and advise other carriers of these methods. Methods that are practical and cost-effective will vary depending on the carrier's overall volume and other considerations. For example, a carrier with a relatively low volume may effectively pre-authorize ambulance transport for ESRD beneficiaries going to dialysis. A carrier with high volume may prefer to electronically suspend, for medical review, ESRD-related ambulance claims when there are more than six transports in a month.

—Inform beneficiaries: advise beneficiaries of the limited nature of the ambulance benefit, and encourage them to call the carrier if the supplier misrepresents Medicare coverage. Carriers could send such a message to beneficiaries directly by mail and through national and local senior citizen groups and newspapers.
—Inform ambulance companies: advise ambulance companies of Medicare's limited coverage of ambulance service and the consequences of submitting bills for transports that are not medically necessary. Carriers could distribute notices to providers directly and through national and local trade associations.
—Inform dialysis facilities: advise dialysis-facility physicians of the limits of Medicare's coverage for ambulance service as they are often the physicians called upon to sign certificates of medical necessity. Carriers could include this advice in their provider education material.
—Conduct post-payment review: periodically, conduct a medical necessity review of ESRD-related ambulance claims.
—Conduct studies: determine what percentage of ESRD beneficiaries being transported to dialysis in ambulances could use wheelchair vans or some other nonemergency vehicle, and whether dialysis facilities would cover the cost of ambulance service (for ESRD beneficiaries who need it) for an add-on to the composite rate Medicare pays for dialysis.

Alternatives to ambulance transportation: like many program officials and advocates, we are concerned about how ESRD beneficiaries who do not have a medical need for ambulances will get to their dialysis treatments. Are other means of transportation available?

To help answer this question, we conducted interviews regarding available transportation in eight cities where patients are being transported by ambulance to dialysis treatment.

We found that transportation appears to be available in most of the sampled cities. Patients use a number of different types of vehicles to travel to dialysis. These include cars, taxis, wheelchair vans, passenger vans, and buses. According to dialysis facility respondents, approximately one-quarter of their patients come in privately owned cars.

Dialysis facility respondents in five of the sampled cities thought that there was enough transportation available for people going to dialysis. Only an estimated 20–22 of the nearly 2000 patients treated at the facilities in our sample occasionally missed treatments due to lack of transportation.

Financial assistance for transportation expenses comes from a variety of sources. These include Medicaid, State kidney programs, the American Kidney Fund, area Agencies on Aging, the American Red Cross, and the National Kidney Foundation.

However, respondents did identify problems in some locations for some patients. In one of the eight cities dialysis facility respondents felt there was not enough transportation for all people going to dialysis. In two other cities respondents did not think there was enough for certain people or in certain areas. Respondents also identified other barriers to access. Three problems were frequently mentioned: long waiting times, costs for patients not eligible for financial assistance, and lack of physical assistance to patients using the services.

This analysis enabled us to draw three conclusions. First, the lack of alternative transportation does not appear to be the central explanation of our data indicating inappropriate use of ambulance transportation. Second, successful approaches to developing a network of transportation options appear to exist. Third, the problems identified by some respondents are also worth more examination. The HCFA is currently conducting further research in this area.

METHOD OF PAYING FOR AMBULANCE SERVICES

Let me now move on to a different issue, which is payment for ambulance services.

Scheduled versus emergency transports.—For ESRD beneficiaries, we have expressed concern that Medicare is paying too much for those scheduled transports to dialysis which are medically necessary. We reported in our 1994 report on payment practices for this population that scheduled transports cost less than emergency transports, and recommended that Medicare revise its payment strategies. One option we suggested is that Medicare pay less for scheduled transports.

Payments based on charges.—This reflects a more general problem about the way Medicare pays for ambulance services. Medicare does not base payments on resource costs, but charges. Ambulance companies are paid based on what they have charged in the past and what other companies in the area charge. Under this system, each ambulance company gets paid a different amount for the same service, and payments may have little to do with actual costs. Advanced life support payments: an-

other example of this is in how Medicare reimburses for different levels of service. Medicare pays more for a claim made for advanced life support (ALS) transport than a claim made for basic life support (BLS) transport. An ALS ambulance contains sophisticated life-saving equipment and is used when the patient needs to be maintained medically while en route to another destination. It is typically used in emergency situations. A BLS ambulance, on the other hand, does not contain the same level of equipment and is primarily used for transportation of medically stable patients. An ALS ambulance is staffed with paramedics, who have more training and are paid more than emergency medical technicians who typically staff BLS ambulances.

However, when an ALS ambulance is used to transport a Medicare beneficiary, payment is made at the higher rate regardless of whether ALS services were actually provided or not. In some jurisdictions, local ordinances require that all ambulances be ALS equipped, and are reimbursed for all their covered transports of Medicare beneficiaries at the ALS rate.

Data that we reviewed and reported on in 1992 indicated that from 1986 to 1989 the number of trips in ALS ambulances increased by 131 percent while the number in BLS ambulances increased by only 14 percent. Allowed charges for base rate ALS and BLS ambulance services increased by $72 million from 1988 to 1989. Of that amount, $53 million or 73 percent was attributable to increased utilization of ALS ambulances. This increase is due, in large part, to HCFA policies which base payment on the mode of transportation rather than the level of service.

One of the best ways to think about this problem is to look at the proportion of total base charges allowed for ALS and BLS services. In 1988, a little more than a quarter of all base charges for were ALS services. By 1993, we're approaching one-half of all base charges being made for ALS services. (Exhibit 4 reflects this growth.) We originally estimated $16 million was lost due to policies which allowed payment at the ALS level when it was not needed. That was for 1989. Since then, the problem has grown—to $47 million in 1993.

Recommendations to HCFA.—We have recommended that HCFA revise its policy to require that payment for nonemergency ambulance service at the ALS level be allowed only when medically necessary. We suggested that HCFA consider the use of physician certification to authenticate the need for the ALS level. We also recommended that HCFA instruct carriers to institute controls to ensure that payments for ALS services are based on the medical need of the beneficiary and that HCFA should closely monitor compliance.

HCFA RESPONSE TO OUR REPORTS

The HCFA has generally concurred with all the recommendations we have made regarding ambulance services for ESRD beneficiaries, as well as ALS/BLS services. These recommendations are contained in four OIG reports on these subjects, which I am pleased to submit for the record.

For ESRD beneficiaries, HCFA is taking steps to revise the coding system and is engaged in a comprehensive effort to improve overall coverage and payment policies, including those involving non-emergency transports.

CONCLUSION

While we certainly agree that medically necessary ambulance services for Medicare beneficiaries is an important part of the program, we also believe that ambulance service should be provided to beneficiaries in a cost-effective manner and controls should be in place to minimize the amount of fraud and abuse. The reports I have described today indicate that there are significant shortcomings in the area of ambulance policy and thus the services provided to Medicare beneficiaries. We are please that HCFA has responded positively to our reports.

This concludes my prepared testimony. I would be happy to answer any questions you may have.

ALS PAYMENTS

Senator HARKIN. Thank you, Ms. Brown. I think before we get into a series of questions, we will go to our next witness, Ms. Buto's testimony.

I just wanted to ask one question about this last chart over here with the increase in the ALS payments, which are now up to almost 50 percent, 43 percent, in 1993. Do you have any idea what

might have happened this year? Has it gone up, stabilized? Do you know?

Ms. BROWN. Well, judging by the way the overall payments have gone up, I would say it would be an even greater amount in 1994, but we have not got the actual figures yet on that.

Ms. BUTO. Could I comment on that a second? Because our numbers are different and I guess we need to compare. Ours show actually that it is closer to 39 percent and it has held at 39 percent over the last 2, 3 years. Are these 1991 data that you are looking at? Is that the basis for your estimates?

Mr. GROB. The estimates that we have for 1993 are based on 1993 data in terms of that percentage. Perhaps later we can work through them.

Ms. BUTO. Yes; compare notes.

Mr. GROB. But there is no significant difference between the 39 and 43, but as far as holding steady for the future, if you have more current numbers——

Ms. BUTO. I think we do.

SUMMARY STATEMENT OF HON. KATHLEEN A. BUTO

Senator HARKIN. Well, Ms. Buto, welcome to the subcommittee. I understand that Mr. Vladeck had a scheduling conflict. Is that correct?

Ms. BUTO. Yes; that is correct, and I am very pleased to be here, Senator.

Senator HARKIN. Your statement will be made a part of the record in its entirety. Again, please proceed.

Ms. BUTO. Thank you, and I want to say that we are also very pleased to work with the inspector general on Medicare ambulance payment policy. I think a number of the things that the inspector general has pointed out, as she noted, we have not only been receptive to, but I hope in my statement you will get a sense of what we have done to respond to them as well.

There have been dramatic changes in the ambulance industry since Congress first authorized Medicare payment for services, the ambulance benefit, in 1965. No longer is emergency transportation limited to a quick trip to the hospital. En route lifesaving techniques have progressed from the elementary, such as giving oxygen and controlling bleeding, to much more advanced services, such as IV administration of drugs and heart defibrillation. A huge array of equipment, supplies, and vehicle capabilities plus increasingly well-trained ambulance staff have made ambulances more efficient at saving lives. These developments have resulted, as the inspector general pointed out, in a rapid increase in Medicare expenditures for ambulance services. While total Medicare carrier payments grew about 50 percent between 1987 and 1992, carrier ambulance payments grew 150 percent during that same period. The rate of increase far exceeded the combined growth in inflation and part B enrollment for that period.

Even though Medicare ambulance payments still account for less than 1 percent of the Medicare budget, this spending increase has raised a flag for HCFA, as well as for the inspector general and the Congress. The inspector general reports, along with findings of the Project Hope Study of Payments for Ambulance Services Under

Medicare, have been the impetus for a number of initiatives undertaken by HCFA to address the growth in ambulance spending while protecting beneficiary access to essential services. These initiatives are being accomplished through a series of administrative and regulatory changes.

For the most part, Mr. Chairman, the inspector general has raised concerns about the requisite controls for ensuring that payment is made only for medically necessary services and about the growing use of advanced life support ambulance services by Medicare beneficiaries. We share the inspector general's concerns and are taking steps to address both issues.

Today I will discuss several of our efforts to address concerns about ensuring that we pay only for medically necessary and appropriate ambulance services. One activity, and a key one, that I wanted to mention is that we have a major ambulance coding project that the agency has undertaken during the last 2 years which will, among other things, directly address the inspector general's recommendations for controlling ambulance use by Medicare beneficiaries with end stage renal disease.

Second, the coding project will provide data necessary for revising Medicare ambulance coverage regulations which will address, among other things, the problem of increasing advanced life support ambulance use identified by the inspector general.

Third, several of the inspector general's recommendations already have been addressed through comprehensive medical review of ambulance claims by educating carriers, beneficiaries, and ambulance companies.

Just to give you an example, the carriers since the inspector general's work—the first report was issued in 1991; 32 of the 43 carriers have instituted or changed their ambulance review policies. Eight of the ones that were looked at specifically by the inspector general's office have made major revisions. Some 41 of the 43 have put in place prepayment screens of some kind for ambulance services, and 23 have put in place that all ESRD ambulance services will be paid on a prepayment basis. So, they are all reviewed. In fact, 10 carriers provide no payment at all for ESRD transportation to facilities. So, a number of things have gone on, as I have said, in that regard.

Let me speak to the revised HCFA codes for ambulance services for a moment. The inspector general's recommendations for developing and clarifying certain ambulance codes served as a catalyst for what has become a major sort of closet cleaning endeavor I guess at HCFA.

In March 1993, HCFA organized an effort to develop a uniform coding system that will improve the accuracy of Medicare ambulance payment which we believe will have a positive impact on beneficiary access while also controlling costs. We recently issued two program memoranda to establish a comprehensive revision to the HCFA common procedure coding system which is known as HCPCS for basic life support and advanced life support ambulance services to establish new origin and destination billing codes for ESRD patient ambulance services and to instruct carriers to use special codes for nonemergency or scheduled transportation by ambulance.

Once the new coding system is implemented by all carriers this January, Medicare will have three times as many ambulance service codes as we previously had which we think will vastly improve our ability to identify patterns of misuse or inappropriate use. More codes will provide greater distinction among ambulance services and, therefore, more information for determining payment amounts.

For example, with today's coding system, we cannot identify trips in which an ALS ambulance was used but no ALS service was actually provided. Once the new codes are implemented, we will be able to tell not only what type of vehicle was used, but whether or not there was an emergency. We will also be able to tell whether an ALS vehicle was used and what services were provided in that vehicle.

HCFA's new uniform coding system will achieve many of the goals implicit in the inspector general's recommendations for ambulance payment reform. For instance, the inspector general recommended that HCFA respecify for carriers the items to be included in the all-inclusive ALS rate. The new codes will do that—have done that actually.

To ensure greater accuracy in monitoring and analyzing Medicare covered ambulance services, the inspector general recommended that HCFA establish a code for scheduled transports and require uniform of national ambulance codes. The inspector general advised HCFA to revise or elaborate on current definitions of national ambulance codes so the distinction among codes are clear to billers and payers alike and to notify carriers that services should be billed under the appropriate code as newly defined in order to be reimbursed.

In addition to implementing new codes and coding changes and reinforcing the proper use of codes, our recent program memoranda clarify such terms as "all-inclusive," "emergency," and "mileage."

As soon as we collect more standardized data as a result of these uniform coding changes, analysis of these data will provide information about patterns of ambulance use and payment that can be used to evaluate payment levels for services nationwide and ultimately design a new payment policy.

As part of the analysis, we will examine whether we should propose to replace the current payment system for ambulance services, which is based on reasonable charges with a fee schedule. As you know, Senator, the current payment policy is specified by law. So, that would require a change in the law.

We are busy actually laying the groundwork for another important change which has been recommended by the inspector general and that is to pay for nonemergency ambulance services at the ALS ambulance level only when medically necessary regardless of local ordinances. We agree that we need to make changes both in manuals and regulations to make it clear when we would pay for ALS and BLS ambulances. Charges for ALS ambulance services on average, as you pointed out, are much too high, and while we do not dispute the value of ALS services when needed, we wish to provide a strong incentive to curb excessive use when not needed.

We are preparing to propose a revised coverage regulation that will include a clarification of ALS and BLS use. The new codes will

allow us to target review and to write these regulations in a way that helps us identify excessive use of ALS services in non-emergency situations. This issue is being examined by a HCFA work group, and I would be glad to elaborate on that later. I do not want to go on at length about that.

As I have already mentioned, we have done a number of things to work with our carriers, our medical review and beneficiary and supplier education.

So, let me start with in August 1994 when we received the inspector general's report, a number of ways for HCFA to ensure that ESRD ambulance claims meet coverage guidelines. I want to point out that it is especially important to note, if you look at the charts, that the data the inspector general is using is basically in this report 1991 data, and while the trends I think, no doubt, are in the direction specified, I guess the good news is, as I look at 1994, our HCFA actuaries are estimating payment more in the neighborhood of $1.48 billion, not $1.7 billion. I do not know if we can claim that is as a result of greater vigilance, but I believe that some of our carrier activities have contributed to that reduction.

HCFA's medical review staff have devoted significant resources and attention to the problem, and as I said, the picture I think now is quite different. We are happy to share that information and have I believe with the inspector general's office.

Since 1991 many carriers have developed modifiers or screens to identify ESRD beneficiaries with high potential for large expenditures. For example, Kentucky Blue Cross has a prepayment edit in place to require ambulance coverage for ESRD beneficiaries to be reviewed every 3 months. Travelers of Connecticut identifies all ESRD ambulance claims. Most Medicare carriers have identified through medical review unusually high ambulance utilization with respect to ESRD beneficiaries and have similar screens in place. I think I gave you the numbers earlier.

HCFA carries out periodic medical necessity reviews of ESRD-related ambulance claims, and using available funding, carriers review claims data and determine when it would be medically necessary to conduct intensified medical necessity reviews for ESRD claims.

In addition, HCFA has implemented a local medical review policy retrieval system that provides carriers with access to each other's policies and that help to identify methods to ensure that medical necessity for all ambulance transport of ESRD beneficiaries is ensured.

Our Office of Research and Demonstrations is undertaking two studies to determine what percentage of ESRD beneficiaries now being transported to dialysis in ambulances could use non-emergency vehicles. One study which is being conducted by the Urban Institute is examining the issue of high cost ESRD beneficiaries using our data on cost and utilization. We expect the study results in the summer of 1995. The second study will examine results of a patient survey that includes questions on the use of ambulance services. That survey, being administered by the National Institute of Diabetes, Digestive and Kidney Diseases, is expected to have results in 1996.

In an effort to increase awareness of our ambulance policies, HCFA sent a letter June 30, 1994, to the Associate Regional Administrators for Medicare apprising them of the inspector general's recommendations. In that letter we asked the regional administrators to have carriers include in upcoming newsletters information on Medicare's limited coverage of ambulance service for ambulance companies and to target that information to dialysis facility physicians. We are including for the record examples of some of the carrier newsletters that have included this information as a result of the June 30 letter.

HCFA has a number of efforts already in place and others in the planning stage to remind and educate beneficiaries of the limited nature of the ambulance benefit. Payment denial reasons are currently included on the beneficiaries' explanation of Medicare benefits. HCFA has suggested that the carriers make ambulance coverage limitations an outreach topic for beneficiaries on carrier customer service plans being developed for fiscal year 1995. In our 1995 issue of "The Guide to Health Insurance for People with Medicare," to be published this January, we will inform beneficiaries about ambulance coverage specifically.

Let me conclude by saying that we believe the coding changes, the impending coverage regulations, and improved guidelines for ambulance use outlined above will bring together greater uniformity in coverage and payment for ambulance services nationwide.

But as we examine ambulance coverage and payment reform, there will be complicated issues to consider. Because of the very nature of ambulance services, we need to develop a policy that results in appropriate coverage and payment of medically necessary ambulance services, but does not discourage use of appropriate higher level of service when it is required. We may be required to make some unpopular decisions to control spending while balancing the needs of beneficiaries in this effort.

In regulating ALS services, for example, how would we determine what Medicare should pay when a triage operator determines that an ALS ambulance is necessary based on clinical information yet in the end only BLS level of services are actually provided.

How should we address the issue of local governments that have explicitly mandated ALS as the sole level of ambulance service to be provided in their jurisdictions, such as in Kansas City and Tulsa?

PREPARED STATEMENT

We will be especially sensitive to these objectives as we proceed with our coverage regulation and beyond that as we examine possible reforms of our ambulance payment methodology. We look forward to working with the inspector general and the Congress as we proceed to change our coverage and payment of ambulance services.

Thank you.

[The statement follows:]

STATEMENT OF KATHLEEN A. BUTO

Mr. Chairman and Members of the Subcommittee, I am very pleased to have the opportunity today to respond to the Office of Inspector General's reports on Medicare ambulance payment policy.

There have been dramatic changes in the ambulance industry since Congress first authorized Medicare payment for ambulance services in 1965. No longer is emergency transportation limited to a quick trip to the hospital. En-route life-saving techniques have progressed from the elementary, such as giving oxygen and controlling bleeding, to the very advanced, such as intraveneous administration of drugs and heart defibrillation. A huge array of equipment, supplies, and vehicle capabilities plus increasingly well-trained ambulance staff have made ambulances more efficient at saving lives. These developments have resulted in a rapid increase in Medicare expenditures for ambulance services. While total Medicare carrier payments grew about 50 percent between 1987 and 1992, carrier ambulance payments grew by 150 percent during that same period. This rate of increase far exceeded the combined growth in inflation and part B enrollment for that period.

Even though Medicare ambulance payments still account for less than one percent of the Medicare budget, this spending increase has raised a flag for the Health Care Financing Administration as well as the Office of Inspector General and the Congress. The Office of Inspector General reports, along with findings of the Project Hope Study of Payments for Ambulance Services Under Medicare, have been the impetus for a number of initiatives undertaken by HCFA to address the growth in ambulance spending while protecting beneficiary access to essential services. These initiatives will be accomplished through a series of administrative and regulatory changes.

As we indicated last March in our Report to Congress on Medicare payment for ambulance services, we also plan to examine Medicare payment policy for ambulance services. As part of that analysis, we plan to examine whether we should propose to replace the current Medicare payment system for ambulance services, which is based on reasonable charges, with a fee schedule.

For the most part, Mr. Chairman, the Office of Inspector General has raised concerns about the requisite controls for ensuring that payment is made only for medically necessary services and about the growing use of advanced life support ambulance services by Medicare beneficiaries.

Today I would like to address the inspector general's concerns by discussing the following issues:

—A major ambulance coding project that HCFA has undertaken during the last two years which will, among other things, directly address the inspector general's recommendations for controlling ambulance use by Medicare beneficiaries with End Stage Renal Disease;

—How this coding reform project will provide the data necessary for a revision of Medicare ambulance coverage regulations which will address, among other things, the problem of increasing advanced life support (ALS) ambulance use identified by the inspector general; and

—How several of the Office of inspector general's recommendations already have been addressed through comprehensive medical review of ambulance claims and by educating carriers, beneficiaries and ambulance companies.

REVISED HCFA CODES FOR AMBULANCE SERVICES

The inspector general's recommendations for developing and clarifying certain ambulance codes served as a catalyst for what became a major "closet cleaning" endeavor at HCFA.

In March of 1993, HCFA organized an effort to develop a uniform coding system that would, in the end, yield three times as many ambulance service codes as we previously had. More codes will provide greater distinction among ambulance services and therefore more information for accurately determining payment amounts. For example, with today's coding system, we cannot identify trips in which an ALS ambulance was used, but no ALS services were provided. Once the new codes are implemented, we will be able to tell not only what type of vehicle was used, but also whether or not there was an emergency. We will also be able to tell whether an ALS vehicle was used and what services were provided in that vehicle. These codes will improve the accuracy of Medicare ambulance payment, which we believe will have a positive impact on beneficiary access to ambulance services.

After consulting in June with the American Ambulance Association, several other industry representatives, and the Medicare carriers to discuss the draft revised ambulance codes and modifiers, HCFA issued two Program Memoranda this Fall to notify intermediaries and carriers of the final uniform code changes.

The first of these memoranda, issued in September, implemented the new origin and destination billing codes for ambulance services furnished to ESRD dialysis patients and also instructed all carriers to use a special code for non-emergency (scheduled) transportation. These codes will allow Medicare to distinguish between trips to hospital-based dialysis facilities and trips to non-hospital-based facilities as well as emergency and non-emergency transportation.

Soon after, on November 29, 1994, HCFA issued the second Program Memorandum which establishes a comprehensive revision to the HCPCS coding system for basic life support (BLS) and ALS ambulance services. These changes are needed to standardize coding for ambulance services and permit ambulance payment and utilization analyses across carriers.

HCFA's new uniform coding system, which must be implemented by all carriers this January, will achieve many of the goals intended by the Office of Inspector General's recommendations for ambulance payment reform.

For instance, the Office of Inspector General recommended that HCFA re-specify for carriers the items to be included in the all-inclusive ALS rate. And, to ensure greater accuracy in monitoring and analyzing Medicare-covered ambulance services, the Office of Inspector General recommended that HCFA establish a code for scheduled transports and require uniform use of national ambulance codes. The Office of Inspector General advised HCFA to revise or elaborate on the current definitions of national ambulance codes so that the distinctions among codes are clear to billers and payers alike and to notify carriers that services should be billed under the appropriate code, as newly defined, in order to be reimbursed. In addition to implementing coding changes and reinforcing the proper use of existing codes, the September and November memoranda clarify terms such as "all-inclusive," "emergency" and "mileage."

REVISING COVERAGE REGULATIONS

Medicare's revised ambulance codes also will lay the groundwork for another important change in Medicare ambulance payment that has been recommended by the Office of Inspector General. In its report "Review of Medical Necessity for Ambulance Services," the Office of Inspector General recommended that Medicare pay for nonemergency ambulance services at the ALS ambulance level only when medically necessary, regardless of local ordinances that may mandate ALS-only services.

HCFA agrees that both the regulations and the Medicare Carriers Manual instructions should be refined to make more explicit the conditions under which a patient is to be appropriately transported by ambulance, for both BLS transportation and ALS transportation. The charges for ALS ambulance services are, on average, almost twice as high as for BLS services. While we do not dispute the value of ALS services when they are needed, we wish to provide a strong incentive to curb excessive ALS billings when ALS services are not needed.

Now that we will have the ability to collect the necessary identifying data, we are preparing to propose a revised coverage regulation that will include a clarification of appropriate ALS and BLS use.

This issue is being examined by a HCFA work group that was convened early this year to develop a comprehensive regulation to modify Medicare ambulance policy to account for a "modernized" ambulance industry. Our work group of ambulance coverage and payment analysts, Medicare regional office representatives, and carrier medical directors is currently meeting weekly to develop a draft regulation by next March. We plan to publish a proposed regulation by late 1995 that will address the major Medicare ambulance coverage and payment concerns—including payment for nonemergency ambulance services at the ALS ambulance level.

In developing our ALS payment limits, we will be mindful of rural areas that have difficulty providing both ALS and BLS services because of equipment limitations and consider making exceptions for those areas, as the Office of Inspector General recommends.

However, the Office of Technology Assessment reported in November of 1989 that most rural EMS ambulance services are providing a BLS level of care with a BLS level of equipment, so we anticipate that this may not be a problem.

After changes have been made in the ambulance regulations and in the corresponding Medicare Carriers Manual instructions, controls, such as those recommended by the Inspector General, can be established at the carriers to ensure that Medicare payment for ALS services is based on the medical need of the beneficiary regardless of the type of vehicle furnishing the service.

MEDICAL REVIEW AND BENEFICIARY/SUPPLIER EDUCATION

As I have just discussed, some issues raised by the Office of Inspector General require reform of our coding procedures and some require us to redefine the basis for coverage of ambulance services. But many of the Inspector General's recommendations could and have been addressed through more comprehensive medical review of claims.

In its August 1994 report "Ambulance Services for Medicare End-Stage Renal Disease Beneficiaries: Medical Necessity," the Office of Inspector General recommended a number of ways for HCFA to ensure that ESRD ambulance claims meet Medicare coverage guidelines. I think it is important to note that the data used by the Office of Inspector General for this report were gathered in 1991. HCFA's medical review staff have since devoted significant resources and attention to the problems identified in this report and the picture is now very different.

While HCFA does not mandate what carriers must review on a pre- or post-payment basis, carriers are required to systematically analyze their claims data to choose those areas of significant overutilization. Carriers then prioritize their findings, choosing the most effective areas for medical reviews.

As a result of these medical reviews, many carriers have, since 1991, developed modifiers to identify ESRD beneficiaries with high potential for large expenditures for ambulance services. For example, Kentucky Blue Cross has a pre-payment edit in place to require renewal of dialysis-covered transport coverage every three months; and Travellers of Connecticut identifies all ESRD ambulance claims. About 50 percent of Medicare carriers now have similar screens in place.

In addition, HCFA has implemented a local medical review policy retrieval system which will provide carriers with access to each other's policies that help to identify methods that ensure the medical necessity of transport for ESRD beneficiaries.

HCFA also carries out periodic medical necessity reviews of ESRD-related ambulance claims. Using available funding, carriers review claims data and determine if and when it may be necessary to conduct intensified medical necessity reviews for ESRD ambulance claims.

HCFA's Office of Research and Demonstrations is undertaking two studies to determine what percentage of ESRD beneficiaries, now being transported to dialysis in ambulances, could use non-emergency vehicles. One study, which is being conducted by the Urban Institute, is examining the issue of high-cost ESRD beneficiaries using administrative data on cost and utilization. Results of this study are expected in the summer of 1995. The second study will examine the results of a patient survey that includes questions on the use of ambulance services. The survey, which is being administered by the National Institute of Diabetes, Digestive and Kidney Diseases, is expected to yield results in 1996.

In another effort to increase awareness of Medicare's ambulance policies, HCFA sent a letter on June 30, 1994, to the Associate Regional Administrators for Medicare apprising them of the Office of Inspector General's recommendations. In the letter, we asked the Regional Administrators to have carriers include, in upcoming newsletters, advice to ambulance companies of Medicare's limited coverage of ambulance service and advice to dialysis-facility physicians of the limits of Medicare's coverage for ambulance service. We are including for the record, examples of some carrier newsletters that have included this information as a result of our June 30th letter.

HCFA has a number of methods in place and planned to remind and educate beneficiaries of the limited nature of the ambulance benefit. Payment denial reasons are currently included on beneficiaries' Explanation of Medicare Benefits. HCFA has suggested that carriers make ambulance coverage limitations an outreach topic for beneficiaries on carrier's customer service plans being developed for fiscal year 1995. And, our 1995 issue of The Guide to Health Insurance for People with Medicare, to be published this January, will inform beneficiaries about ambulance coverage.

CONFRONTING DIFFICULT ISSUES

We believe that the coding changes, the impending coverage regulations, and the improved guidelines for ambulance use outlined above will bring greater uniformity in coverage and payment for ambulance services nationwide.

But as we examine ambulance coverage and payment reform, there will be many complicated issues to consider. Because of the very nature of emergency services, we must consider the very critical, possibly life-threatening consequences of limiting ambulance care. We may be required to make some unpopular decisions to control spending while balancing the needs of our beneficiaries in this effort.

In regulating ALS services, for example, how do we determine what Medicare should pay when a triage operator determines that an ALS ambulance is necessary, yet in the end only BLS services are needed?

And how should we resolve the issue of local governments that have explicitly mandated ALS as the sole level of ambulance service to be provided in their jurisdiction, such as Kansas City and Tulsa? Should the Federal government pay only ALS rates because of a local mandate? Or should the locality be responsible for the extra cost of their mandate?

CONCLUSION

In considering all of these issues, we must also consider the impact on beneficiary care and access and make sure that we are not saving money falsely by foregoing essential services.

We will be especially sensitive to these objectives as we proceed with our coverage regulation and beyond that, as we examine possible reforms of our ambulance payment methodology.

As soon as the new uniform coding changes that I have discussed today begin producing data, analysis of these data will provide information about patterns of ambulance use and payment that can be used to evaluate payment levels for ambulance services nationwide, and ultimately, to design new payment policies.

HCFA looks forward to working with the Congress as we proceed with these policy reviews.

ALS SERVICES

Senator HARKIN. Ms. Buto, thank you very much for your testimony.

I might just start where you ended there when you talked about local jurisdictions that have mandated that only ALS services be provided in their jurisdictions. You asked the question, should the Federal Government pay only ALS rates because of a local mandate? The inspector general says no. We do not have to adhere to a local mandate. If that is what they mandate, fine. Let them pay it.

Ms. BUTO. Yes; and I have to say that I think there is a lot of support for that in HCFA as well. I think the question is if we are going to transition entirely to BLS level of payment, how we make that transition in areas where more expensive equipment is provided. Maybe we go cold turkey to the lower level. We can do that. In other areas of Medicare where we really sort of required cuts of that magnitude, we have tried to give folks a little time to adjust to that. But we agree with that basic conclusion.

Senator HARKIN. You agree with the basic conclusion that regardless of what local jurisdictions have mandated, that HCFA does not have to pay the ALS. They can pay a BLS rate or some lower rate.

Ms. BUTO. We should be paying the medically necessary, appropriate rate to provide that service at whatever level.

Senator HARKIN. Well, you seem to have a hesitancy on doing something cold turkey.

You said that 10 Medicare carriers have stopped all payments for ambulance trips to kidney dialysis. Is that right?

Ms. BUTO. Many of those have not ever paid for ambulance transport to dialysis services. So, that is their policy.

Senator HARKIN. They never did pay. They did not stop paying.

Ms. BUTO. I do not have the breakdown—but we can provide that to you, Senator—between those that have stopped and those that have never started.

The staffer is saying that the medically necessary hospital services are provided in many of those areas. In other words, if an ESRD patient is transported to a hospital for a medically necessary dialysis service, they can get covered. It is the freestanding no payment that I should have been clear about. They are not paying for any dialysis transport to freestanding facilities, and that is what the 10 are doing. How many of them were doing it before and how many have stopped doing something they were doing prior to the inspector general's report I cannot tell you, but we can find out.

Senator HARKIN. In other words, they will pay for the transportation to a multipurpose hospital, but not to a freestanding kidney dialysis center. Is that what you are saying?

Ms. BUTO. Some of them will. It should be based on medical necessity, though, as you know.

Senator HARKIN. Let me ask you this. If a carrier decides to stop payments for ambulance trips to kidney dialysis centers—and there are some that you say that have—is that allowable under your current policy?

Ms. BUTO. Under current policy, unless we have a national rule, usually through regulation and followed up by instruction, the carriers have a lot of discretion to respond to their local circumstances. So, yes, they can apply their own discretion in deciding, for example, what screens to apply and what to allow payment for.

Senator HARKIN. It just seems to me, Ms. Buto, that if this is allowed under current rules, a drastic change like that where they can just say we are not going to pay it anymore, then I do not know why it is so difficult to make what I consider to be relatively minor changes like making sure that HCFA pays only for ALS when ALS is provided. I do not understand why that is so difficult.

Ms. BUTO. You are asking why can we not just change the policy now, and not follow regulations.

Senator HARKIN. Let's read the regulation.

Ms. BUTO. OK.

Senator HARKIN. Section 5246.4. The carriers' manual requires a reduction in payment to the lowest level necessary to meet the patient's medical need. I will read the section.

When the level of service reported on a claim is not reasonable and necessary, that is, when it has been determined either by you or by a peer review organization pursuant to a contract with the Secretary, that a less expensive level of the service would have met the patient's medical need or when a less expensive level of the service was actually furnished, reimbursement must * * *.

Not may, but must——

* * * be based on the reasonable charge for the less expensive level of service. Section 5246.4.

Ms. BUTO. I guess what I am saying—and I know this sounds amazingly detailed—is that our current coding system does not even allow us to distinguish. For example, we have a code for nonemergency ambulance services. It does not distinguish between ALS and BLS level of service. The codes that we are putting into place in January allow us to know whether the service was actually provided or not.

Senator HARKIN. But you can change those codes tomorrow.

Ms. BUTO. We have changed those codes, sir. We have changed those codes. They have been issued and they are going into effect in January. Although we can change the codes and we did change the codes—and I think we have issued 20 some odd new codes as opposed to the 4 or 5 we had before—the carriers do not turn on a dime. Unfortunately for many of us, it takes systems changes to make those codes.

Right now in fact we got calls from Senator Hollings' office that there are concerns that the crosswalk of the old codes which are so few to the many new codes to make sure that the charges go into the right places, that we do that carefully so that we do not either underpay BLS services, for example, for nonemergency or overpay ALS nonemergency, that we make those carefully crosswalked so that we know when they go into effect in January what we are going to pay for each of those services.

Senator HARKIN. Is this a proposed rule change?

Ms. BUTO. This is a manual instruction change. It is going into effect in January right away. So, although that is not tomorrow, it is close, as close to tomorrow as we can get.

Senator HARKIN. I am trying to keep this straight in my own head. My staff informs me the changes in the codes that you are talking about really will not save any money. It just provides for different reporting. Is that correct or not?

Ms. BUTO. It will not save any money.

Senator HARKIN. OK, it will not save any money.

Ms. BUTO. Correct.

Senator HARKIN. What will save us money?

Ms. BUTO. What will save some money is being able to identify patterns of inappropriate medical use. These codes for the first time begin to identify the differences between ALS and BLS levels of service that can tell you whether one was needed and whether you have outliers, if you will, that you can go after. As you pointed out in the regulations, we have plenty of authority to go after outliers when we can identify when there is medically inappropriate use.

Incidentally, if the inspector general can tell you, I hope she will also let us know—and I am sure she will—what cities and what specific suppliers. We are also trying to do that investigation, but it makes sense to sort of collaborate so we can hone in on the bad apples in the process as well.

Can I speak to the issue of what will save money?

Senator HARKIN. Well, yes, I am going to ask you. I understand that there is a proposed rule on ambulance reimbursement rates that you are promulgating. Is that right?

Ms. BUTO. There is a proposed rule on coverage and payment. It is going to be mostly coverage.

On payment the law requires us to pay on historical charges, as was pointed out by the inspector general's charts. This chart here with the $130 to $183 represents current law. It says pay the lowest of the actual charge, the supplier's customary charge, what the supplier usually charges, or the prevailing charges of all of those suppliers in an area. Actually that is not a startling difference. We can have even greater differences if you have subsidized ambulances, for example, versus the nonsubsidized. But that is current

law. That has to be changed by law if we want to change the payment system.

Senator HARKIN. You have two ambulances here doing the same trip. One is paid $130 and one is paid $183. Now, tell me why you have to pay the one $183 and why you cannot pay at the same rate as $130.

Ms. BUTO. The $130 is likely to be that ambulance supplier's charge which is lower than the prevailing rate. The $183 I am assuming is the prevailing rate. It is, when you take all averages of all trips of that type, what we are paying for that service. One ambulance company is providing it at a lot less. We would like to be able to pay under some other method, but the current method is you pay each supplier based on its actual charge, the lowest of, its actual charge, the prevailing, or its customary charge.

Senator HARKIN. Well, if the actual charge is $130, it would seem to me that is what you would have to pay.

Ms. BUTO. Yes; those are different ambulance companies for the same trip. Take the $183. That $183 might represent a charge of $250 and $183 is the prevailing charge in the area. So, we pay the lowest of each company's actual charge. You do not pay the lowest of any actual charge in the area.

For example, the $130 might have two ambulances. It might be a major metropolitan area. It would not have the capacity to provide the service to everybody in the area who might need it. You have got to work with, under our law, all the suppliers who can provide the service and pay them the lowest of those three things.

Senator HARKIN. Why would you not just have a set fee schedule?

Ms. BUTO. That would require legislation. That is something we are thinking about proposing by a legislative change.

One important building block, though, just getting back to codes, is that you need the codes to figure out what appropriate levels should be for the different types of services in what settings and whether you want to bundle payments in an all-inclusive rate or whether you want to not bundle payments. In order to do that, you need to separate out charges for different kinds of ambulance.

Senator HARKIN. I still do not understand the HCFA policy here where they require a reduction in payment to the lowest level necessary. I read that section. There is another section that advises carriers to monitor suppliers to ensure that they practice economical care. The repeated use of ALS ambulances in situations when carriers should have known that less expensive BLS ambulances were available and medically appropriate constitutes uneconomical practices by suppliers.

It says here, in this same section, 51116.1 of the carriers' manual, allows carriers to pay ALS rates when an ALS ambulance is used even if only a BLS level of service is necessary. This is supported by HCFA guidance sent out on February 5, 1990. I am just reading from HCFA's statement here. The memo says, HCFA does not at this time make a coverage distinction between ALS and BLS services.

Now, is this what you are getting at with these new codes?

Ms. BUTO. We are going to undo that if that is what you mean by getting at.

Senator HARKIN. You are going to undo that.

Ms. BUTO. Yes; because the codes do not currently distinguish very well, we are going to tease them apart so we can distinguish and go after outliers, as well as develop more appropriate payment methodologies for the different levels of service.

Senator HARKIN. Again, I guess the point I want to get to is that the codes that you publish will not get to that. Only a final regulation change will get to that. Right?

Ms. BUTO. That is right.

Senator HARKIN. When can we expect to see that final regulation?

Ms. BUTO. The final regulation is being prepared now. We hope to issue it next year. The schedule currently is that we would issue it, I guess, the fall of 1995.

Before you jump in—it is a proposed rule, right, not the final rule, which is even worse.

The other thing we are thinking of is that they are not unrelated. Once we get better information as a result of codes, we are in a better position to do the thing you pointed out in the manual instructions, which is to look at uneconomical patterns of use, and we plan to do that. We will have a better basis then to reduce levels of payment under our current authority even without a change in regulations.

Our lawyers tell us, however, that in order to impose a totally different set of standards or a national standard on all carriers as regards medical necessity, what ALS level is, the fact that we are not paying based on type of transport anymore, et cetera, that we really need to lay that out more specifically what we mean by mileage and how we would pay for it and so on. You need regulations to really have that stand up to what we think might be challenged by a number of ambulance companies.

So, we are going to proceed both on the track of going after the uneconomical under current law, as you pointed out, using our new code and information from that while also doing the regulations. And I would be glad to address the timeframe for regulations, which is protracted. It takes a long time.

Senator HARKIN. I do not understand that. I really do not understand that. You are talking about a proposed rule at the end of 1995 which means that it probably will not be until 1996 before we get a final rule.

Ms. BUTO. Yes.

Senator HARKIN. So, we have got to go through an entire year and a half with this same kind of nonsense going on. Please, Ms. Buto. I cannot explain that to my taxpayers. I just cannot. There is no reasonable way that I can explain that. You have known about this—I do not mean to pick on you, but HCFA has known about this since 1992. That is when the inspector general first came out with this report. It is now 1994 and we are told it is going to take a couple more years. It does not make sense.

Ms. BUTO. While regulations are important, they are not all we do. I think I have already pointed out that I think we have already reduced what the inspector general would estimate the payout would be for ambulance as a result of a number of steps already taken to put in prepayment screens as well as medical review.

With the codes in place this January, we intend to go after the uneconomical patterns of use without regulations. We can do that under our current authority, and we can do it carrier by carrier. And we will do it.

The regulations take a long time for several reasons. One reason is anytime we talk about Medicare, even though this is a reasonably small part of Medicare, less than 1 percent, the review and scrutiny both around health and safety issues and around budget issues, that is, can we cut more, could we save more, et cetera, is this the right payment policy, is intense. We have a mandatory statutory 60-day comment period for all Medicare regulations. The development time—and we could lay out the scenario for you—for the best case, which is the prospective payment regulation for Medicare hospitals which affects more than $65 billion—the best case scenario there is it takes us 9 months to do a proposed and final regulation by September 1.

The reason for that is if you want to use the most recent data to set payments for hospitals, you have got to wait to get data to make good judgments about what the payment level should be. Since so much of the economy of hospitals is dependent on that, we spend the time to get the data right up to date as close as we can. We do that with all payment regulations, and we would look at the impact on those that are affected, both beneficiaries, providers, and States, for example, or cities, of any changes we make. So, it takes us that long with a 60-day comment period and sometimes hundreds or thousands of comments.

All I can say is that is our experience. Two things we are doing could try to streamline that are flatten review, because review time takes a lot of time, so that the Department and OMB and HCFA are all working together at early stages of the regulation. We are beginning that process now, and we have already accomplished that successfully.

The second thing is negotiated rulemaking where we actually sit down with all the parties and try to work out in advance, so you do not get sued, some of the terms of regulations. On this one we do not think we are doing negotiated rulemaking.

But there are a number of ways we are looking at to just get that review time down because it takes a while to clear a regulation through the many steps in the process unfortunately.

Senator HARKIN. Well, which leaves aside again the question of why it is just starting now and it did not start 1 or 2 years ago.

Ms. Buto, you indicated as a result of the inspector general's findings with regard to ambulance transportation for dialysis patients, about 50 percent of the Medicare carriers now have screens in place to identify these claims. Is that right?

Ms. BUTO. Prepayment screens for ESRD, yes.

Senator HARKIN. Well, why does HCFA not just mandate that all carriers must review certain types of claims that fit a profile of abuse?

Ms. BUTO. We have learned probably the hard way that when we mandate the same set of things be looked at by all carriers, that we do not necessarily make the best use of our review dollars. Review dollars are very tight, and what we do with carriers is provide them with the information about their performance or their ex-

penditures in categories compared to national norms. They tend to make the better judgment about the use of their review dollars than we do. If we mandate everybody look at physician office visits, for example, that means a lot of resources go into that and whole other areas that are important in those carrier areas get left unreviewed. So, we do not think we have necessarily the best answers in that regard.

Senator HARKIN. Again, I think your point might be well taken if we were talking about a minority of the claims. Right over here, end stage renal dialysis patients; 70 percent, according to the inspector general's office, do not meet Medicare guidelines.

Ms. BUTO. Yes; I would think that is not 70 percent any longer because this is based on 1991 data, as it says, and a lot of effort has gone into place since the inspector general's report at the carrier level. We can look at the last quarter of data, for example, with the inspector general or provide it to the inspector general for an update, but I am sure it is not that high. I think they have already taken steps to curb that.

Senator HARKIN. Well, but you still say only one-half have payment screens. Right? Only one-half of them.

Ms. BUTO. I am sorry. My staff reminded me. It is prepayment screens that one-half have. All of them have ambulance review policies.

Senator HARKIN. That is right. So, if 50 percent have prepayment screens——

Ms. BUTO. Many of them have postpayment screens. They look afterward to see what has happened and they go and deny payment. So, depending on their needs, they have chosen to do it one way or the other.

Senator HARKIN. Ms. Brown, do you have any more recent data on that?

Ms. BROWN. All of the charts that show 1993 data—we have done the research, and that is not an estimate. That is actual. So, it is not in our report; 1991 is what the report was based on, but it was updated for this hearing. So, these increases have continued through 1993 and we believe they are is accurate.

Ms. BUTO. I guess we just have a difference between the HCFA actuaries and the inspector general's office then.

Mr. GROVE. Perhaps if I could make a clarification, it might help.

Senator HARKIN. Please.

Mr. GROVE. With regard to the ESRD patients particularly, I do not believe we have a real difference on what the total outlays are. Ms. Buto raised the question of whether the 70 percent was still an accurate number. We used the 70 percent from 1991 because that would require resampling to update that number and applied it to the 1993 expenditures.

Now, it is true that the 70 percent may not be the right number exactly for 1993, and we would certainly agree that many of the things that Ms. Buto has outlined that have taken place are probably ameliorating this problem. But I would like to point one thing out if I can.

The payments that were made for these beneficiaries should not have been made. So, the problem here is that if we were really being as successful as we think we need to be, it is not sufficient

for the curve to level off. It has actually got to go back down. In other words, we will be able to tell that we have been successful when that curve actually starts going back down again and we are not making payments that we should not have made.

With that in mind, all estimates, even actuaries' estimates like ours, are guesses about what the future will be and there are probably perhaps some valid reasons for differences here and there. But the general thrust of what we are saying is true. I will, however, again want to say that HCFA has taken actions which we think are having an effect.

Ms. BUTO. And we agree with the conclusion that plateauing would not be a satisfactory outcome. We are looking to eliminate the medically unnecessary higher payments.

Senator HARKIN. I am glad to hear that you are saying that changes have been made, but when I look at a chart and I see this thing going up at 33 percent a year, something is wrong. Maybe you have taken some actions to keep it from going up 40 percent a year or 50 percent a year, but 33 percent a year is unacceptable. Totally unacceptable. How can you possibly explain that? I am sorry. The population you are serving from 1989 to 1993 has not changed that dramatically. I am sorry. It just has not. When costs triple—yes, almost triple—you cannot explain that. Unless you can show me that something has happened in America where there is triple the number of ESRD's, that there is triple the number of people that have to be taken to the hospital—you cannot show me that. The data is not there.

Ms. BUTO. I just wanted to point out again—and we need to submit this for the record with our source, but our figures are showing that annual growth rates peaked from 1990 to 1991 and that the growth from 1991 to 1992 was 13.2 percent and from 1992 to 1993, 12.2 percent. So, again, you cited 30 percent and I guess I do not——

Senator HARKIN. Well, that was average over the last 6 years.

Ms. BUTO. Again, we think the recent actions——

Senator HARKIN. Tell me. Does that slope of that line look like it is coming down to you?

Ms. BUTO. Since 1991 a lot has changed.

Senator HARKIN. Well, I have the data for 1992–93. Show me the slope of that line.

Ms. BUTO. Yes; I can show you the slope of that line. I am saying that we do not agree necessarily with the numbers on their chart.

Senator HARKIN. Back up. You do not agree that the total ambulance costs under Medicare part B are as indicated on that first chart?

Ms. BUTO. Yes; we disagree with the bottom line numbers.

Senator HARKIN. You are saying that the numbers that I have listed on that chart, the total ambulance costs under Medicare part B—you do not agree with those numbers.

Ms. BUTO. Yes; let me just read the note that I was just passed because I am not having time to digest this. The inspector general's total spending figures are allowances, including copayments by beneficiaries. Is that correct?

Mr. GROB. That is correct.

Ms. BUTO. The 1994 figure that I quoted as the actuaries' estimates of payments that is what Medicare pays out. So, we are not that far apart on the totals, just to be clear.

Senator HARKIN. These are the total costs. These include the part B costs, and I said that in my opening statement. Not only are the taxpayers getting ripped off, but the elderly and the disabled are getting ripped off too. So, you do agree that these are the total costs.

Ms. BUTO. I gather we do. They are close enough. They are close.

Senator HARKIN. Now, I would like to take a look at the numbers, Ms. Brown, of what the payments have been. I would like to see if the slope of that line has come down dramatically. I have a suspicion that it has not come down all that much, but regardless of that, I think we have an obligation also to the elderly under part B to make sure that they are not paying these unnecessary charges and obviously they are.

Ms. BUTO. We agree. If we did not agree, we would not be here saying that we are going to change our coverage policy so that we can go after the excessive payments.

Senator HARKIN. Again, still the taxpayer is getting stuck with the bill anyway you look at it.

Ms. BUTO. Yes; we agree we need to change it.

Senator HARKIN. Well, OK, then let us not get into nitpicking here about whether or not it is only 12 percent or 13 percent. The increases in the total ambulance costs under Medicare part B is going up at a steady rate and it has not come down. Your thrust seems to be, well, it is fixing itself and it does not look like it is fixing itself.

Ms. BUTO. I did not mean to imply that. I think we have to take action to fix it which is why we issued these codes and why we are going to issue a regulation to change that aspect of it and to go after the uneconomical patterns of growth to get the medically unnecessary services down.

Senator HARKIN. Ms. Buto, we had a hearing here a year or so ago—maybe it has been 2 years ago—on the issue of alcohol and lobbying expenses and things like that. I am sure you were here. I think Mr. Vladeck testified at the time.

Ms. BUTO. Yes;

Senator HARKIN. This created quite a scandal. HCFA changed without a regulation by carrier manual change the allowed payments for alcohol and lobbying. They did not take 2 years. They just went ahead and did it. Why can we not do it here the same way?

Ms. BUTO. The underpinnings for that payment system, which is the cost-reporting principles of Medicare, were there. There was a framework on which to make interpretations of what a reasonable payment is for those kinds of expenses. Those underpinnings are there. The underpinnings for this change are not there, and that is what we are putting in place now. The ability to identify patterns and to say what is not allowed is not there. We have never specified ALS level, BLS level, and what we do not allow, and so on. This will be the first time, and we have to put that in place before we can sustain a change like this.

We are, as I say, going to proceed anyway even without the authority to try to hone in on the outliers.

Senator HARKIN. You changed this lobbying/alcohol thing in 30 days. You are going to have your codes out the end of this month. Right?

Ms. BUTO. They are out already.

Senator HARKIN. They are out now.

Ms. BUTO. Yes; they were issued in early December. We give the carriers about 1 month to actually change their systems to put something in place.

Senator HARKIN. I guess I still do not understand then why it is going to be mid-1996 before we get these final rules. I have been through rulemaking. I have been here a few years, and I have seen rules promulgated. You have your 60-day comment period and a final rule done on very intricate things done within a 6-month period of time. And I do not understand why this is going to take a year——

Ms. BUTO. Sir, I do not believe there is a regulation in the Department of Health and Human Services that has been done in that time, but I could be wrong.

Senator HARKIN. I grant you, not Health and Human Services. It was a different Department.

Ms. BUTO. With Medicare's share of, if you will, the budget picture and the deficit, we go through extra scrutiny as a result of that. Again, the health and safety issues are significant too.

Senator HARKIN. But you can understand why I get a little frustrated.

Ms. BUTO. I am frustrated too.

Senator HARKIN. I was going to bring it with me. I did not. The blood glucose monitor. Remember we had that hearing about a year ago, and we pointed out the blood-glucose monitors—at that time my staff went out and bought one locally for $50 and HCFA was paying $187 for them. Is Medicare still paying $187 for blood glucose monitors?

Ms. BUTO. The only thing I know about exactly where that is is that the regulation is out of HHS and under review right now.

Senator HARKIN. Well, I am told they are and it has been a year. You can still go down and you can buy them for $39, someone told me, now. And HCFA is still paying $187.

We bring these things out in these hearings. We try to operate in good faith. We try to give all the respect and due consideration that we can, and yet it just drags on and on and on. So, we get very frustrated.

Ms. BUTO. Senator, just one comment on that. We are frustrated too. Some years ago a number of our carriers were applying inherent reasonableness at the local carrier level to do just what you point out, which is to go after in their area abuses. As a result of their actions, though, the ability of carriers to move quickly was removed as you probably know. We have to, in order to do inherent reasonableness now, go through national notice and comment rulemaking. We have been put through a number of additional hoops. It is frustrating because when we see an abuse, we would like to be able to move quickly. We feel like in some sense some of those authorities have been taken away from us.

Senator HARKIN. Congress ordered a study of ambulance services as part of the Omnibus Budget Reconciliation Act of 1989. In 1991 we got a report back from the contractor to HCFA. In 1994, this year, the Secretary reported the results back to Congress; 5 years. So, this is not only not explainable, I think it is totally unreasonable that we take so long on these things.

Are there legislative changes that we must do in order to get at the tremendous growth in ambulance costs, or can you do that by regulation? Can you change at all? Can you do it? Can you take care of it yourself, or do you need us to change the law?

Ms. BUTO. Let me tell you what we can do and let me tell you what you could do. What we can do is find out under our current rules where there are excesses and inappropriate medical necessity, and we can go after those cases. We intend to do that. We cannot change the other thing which is the payment system which requires us to pay the lowest of the actual charge, the prevailing charge, or the customary charge of that category of supplier. If we wanted to go to a fee schedule, that would require legislation.

Senator HARKIN. You are saying that in order to get at the $130 or $183 discrepancy and the changes in Medicare savings here——

Ms. BUTO. No; let me be clear about the savings, sir. Sir, just to be clear about the savings, the savings you can accomplish—maybe not all of them, but you can accomplish savings by paying for appropriate level of service based on medical necessity. I think all of us would agree with that. That is current law and we ought to be able to apply that better. I think that is what we are all working toward. If you want to even payments out to a fee schedule, you need legislation. That is all I was saying.

Senator HARKIN. So, in terms of the 5-year potential Medicare savings on that total overpayments of $564 million, which is one-half billion dollars, you could do that by regulation.

Ms. BUTO. I do not know if we would agree on the amount, but we can do a lot by regulation, I think, and targeted enforcement.

Senator HARKIN. That is really the bottom line. That is what we are trying to do is save that money.

Ms. BUTO. Absolutely.

Senator HARKIN. So, you can save that money without legislation.

Ms. BUTO. I believe we could save a lot of that money without legislation.

Senator HARKIN. Do you agree with that, Ms. Brown?

Ms. BROWN. Yes, sir; that estimate is based on 5 years at the same rate. Now, if anything, it is conservative because everything has shown a rate of growth in these areas. So, you have just projected the 5 years based on the latest information assuming no growth or no growth in the conversion to advanced life support transportation. So, I think that is a conservative estimate.

Senator HARKIN. Well, it seems to me that is really what we are talking about, saving one-half billion dollars over 5 years. If it takes a couple more years to get the regs out, that is not——

Ms. BUTO. Again, I do not think we need the regs to begin saving that money. Now that we have codes, we ought to be able to identify those inappropriate levels of service and begin to save that money by targeting our carrier resources on those outliers. That is

what we are talking about, the inappropriate level of service. That we can do with new codes fairly soon I think.

Senator HARKIN. Now, you talked about fee schedules would require a change in law. How about just for bids, just putting in bids for services in local areas?

Ms. BUTO. That would require a change in law too. A competitive bid?

Senator HARKIN. Yes.

Ms. BUTO. I know that because we have designed a number of competitive bid proposals in Medicare.

Senator HARKIN. I am told by staff you could do some demonstrations on bidding. It might be interesting. Good, old, open competitive bidding.

Ms. BUTO. I would love to do a demonstration on competitive bidding. The one thing we cannot do under our demonstration authority is make everybody play, if you will. We cannot require all suppliers, for example, to bid. What we have discovered when we put out a proposal like that, you get folks who think they are going to sort of win in some sense, maybe attract more volume or set a bidding price that they feel is good for them, but you may not get everybody. So, you continue to have on the other side charges that are very different. It does not give you a good picture of what might happen in a true competitive situation where people really have to bid for the Medicare business.

The other thing we cannot do is lock beneficiaries into a competitive bid demonstration. So, they could continue calling other ambulance services.

So, there are some problems with the demonstration authority although it is a good route to take.

Senator HARKIN. Let me just finish on one note here. Ms. Brown testified that there was one case of one individual who received $82,000 in ambulance services in 1 year for 280 trips. How could that possibly happen?

Ms. BUTO. Is this a dialysis patient?

Mr. GROB. Yes.

Senator HARKIN. $82,000.

Ms. BUTO. Assuming the individual was getting ambulance transport to and from the dialysis service—that is three treatments a week times two. Six trips a week times 52 weeks is 300 trips.

Senator HARKIN. I thought it was three trips a week for dialysis.

Ms. BUTO. But then it is to and from, I assume.

Senator HARKIN. Oh, a trip is one way.

Ms. BUTO. Were you counting them individually?

Mr. GROB. We counted all the trips. There is no way around it. That is an outlier.

Ms. BUTO. That is definitely an outlier.

Mr. GROB. All of the dialysis patients that we have up there were all basically three times a week to hospital based or appropriate approved centers. So, a small number were getting a lot.

Ms. BUTO. The other thing we have been trying to figure out—and maybe you could help us with this—is whether there are certain dialysis centers that are promoting the use of regular ambulance transport so we can work with the centers because we pay the centers as well as the ambulance companies. In some sense we

have even more leverage with them. So, if we can begin to identify those outliers, we ought to be able to get those cases way down or eliminate them.

Mr. GROB. We are happy to share all the data we have gathered with you in our sample.

Senator HARKIN. I am sorry. I cannot hear that.

Mr. GROB. We are happy to share all of our data with HCFA as we do routinely, and we will be happy to work that way.

Senator HARKIN. Well, it just seems incredible; $82,000 in 1 year just for trips to the dialysis center.

What was the figure again you used that most people used cars or vans? What was that figure?

Mr. GROB. We did not compute a percentage on that one. What we did was, since we were concerned that we might cut people out who needed the service, we went to the centers in the areas that we had been working to find out what they were doing, and while we do not have a percentage, the vast majority were able to find alternative means of transportation. Those that were not could probably well learn from those that could.

Senator HARKIN. Well, I just have this for 1991. That was $82,722. I just wonder what it was like last year. In 1991 there were 355 beneficiaries who averaged $61,415 in claims paid for ambulance transportation. That is just mind-boggling.

Ms. BUTO. We do not think that is the current picture for all the reasons I have mentioned about the special screens that have gone in on facility runs, but again we would be happy to look at the last quarter of data or some more recent period to see what is happening there.

Senator HARKIN. You may say that is not the current picture, but something is happening because I keep going back to the slope of the line is not going down.

Ms. BUTO. Yes; and I do not think that is the ESRD issue. I do not know if you would disagree. ESRD only represents, although it is a lot of money, $150 million out of the $1.7 billion or $1.5 billion. That picture has to do with the ALS/BLS medical necessity for all ambulance transport, and that is really a much bigger problem.

Senator HARKIN. I understand.

Ms. Brown, did you have anything else that you wanted to add that may have come up in my question and answer session here?

Ms. BROWN. No, Mr. Chairman. I think that it was pretty thoroughly covered.

Senator HARKIN. Well, I want to thank this panel. Ms. Buto, thank you for being here.

Again, while I give up the chairmanship of this subcommittee at the end of this year, I can assure you that I have spoken with my successor, Senator Specter, and he feels as strongly about this as I do. So, we will continue on with this next year. I am sure that sometime shortly after the first of the year we will be having another hearing to again try to get HCFA to move a little bit more rapidly on these proposed regulations.

I think we really need to find out why it is taking so long to get the proposed regs out when we have known it. This is not something that just came up today. I am having the hearing today. You have known about this a long time. The inspector general's office

has known about it a long time. The reason we are having the hearing is we are frustrated that nothing gets done and it just keeps dragging on and on, and now I am told it is going to be another 1½ years or so before anything gets done. That is just not acceptable. I will convey that myself to the Secretary of HHS. It is just not acceptable.

Thank you very much.

NONDEPARTMENTAL WITNESSES

STATEMENT OF MARTIN YENAWINE, PRESIDENT, AMERICAN AMBULANCE ASSOCIATION

ACCOMPANIED BY JOSEPH R. PAOLELLA, CHAIRMAN, GOVERNMENTAL AFFAIRS COMMITTEE

MEDICARE REIMBURSEMENT

Senator HARKIN. Next we will hear from Martin Yenawine—I hope I have pronounced the name correctly—president of the American Ambulance Association. Mr. Yenawine, thank you for being here. Your statement will be made a part of this record in its entirety. Please proceed as you so desire and tell us you are not all bad actors out there. All right?

Mr. YENAWINE. Thank you, Senator. I certainly hope to.

Good morning, Mr. Chairman. My name is Martin Yenawine and I am president of the American Ambulance Association. I am accompanied today by Joseph Paolella, who is chairman of our Governmental Affairs Committee.

The American Ambulance Association deeply appreciates this opportunity to testify on the issue of Medicare reimbursement for ambulance services. We are the national trade association representing the organizations who provide fee-for-service ground ambulance transportation.

Mr. Chairman, we understand the purpose of today's hearing is to examine the findings of the inspector general in the areas of Medicare reimbursement for dialysis-related transportation and for advanced life support services. We are prepared to address both areas.

First, dialysis. The inspector general has raised concerns about the incidence of fraud and abuse. Where fraud exists, we fully support their efforts to ferret it out and prosecute the wrongdoers. Our association abhors willful abuse of the Medicare system. In fact, we go to great lengths to educate our members about the complex rules governing this area. We have also met with the inspector general's office on numerous occasions, giving them our recommendations for eliminating fraud and abuse in this area.

Unfortunately, this type of service has many unique characteristics and it is just very costly. On average end stage renal disease patients require six transports a week. This can result in per patient costs in excess of $30,000 annually. Therefore, overpayments due to fraud, abuse, or carrier error have resulted in the significant dollars lost to Medicare. To repeat, the American Ambulance Association is fully supportive of the efforts to eliminate overpayment in this area and we will continue to work with HCFA and the inspector general to see that this is accomplished.

Let me now turn to the most recent inspector general report on end stage renal disease entitled "Medical Necessity." In that report

the inspector general states: "70 percent of dialysis-related ambulance claims across 16 carriers with the highest allowances did not meet Medicare's coverage requirements for medical necessity." While we cannot evaluate this statement without reviewing the data that the inspector general used, we agree that there are claims paid by Medicare which do not meet the medical necessity criteria for coverage.

We believe a significant part of this problem, however, is caused by the confusing and often conflicting rules which result in a gray area surrounding this question of medical necessity. In fact, there is an early inspector general report on dialysis which concurs with this opinion or belief. "We question whether the coverage guidelines are clear enough to identify inappropriate payments. This lack of clarity has produced a significant area of program vulnerability."

Because the coverage guidelines are unclear, Medicare coverage for ambulance transportation is uncertain even though the ambulance provider may have acted in good faith. We concur that the judgment about whether a patient's condition meets all the medical necessity requirements for Medicare coverage should be based on the evaluation of all information pertaining to the patient's condition. Would it not be in the interest of the patient, the provider, and the Medicare coverage to determine the coverage before the ambulance service is provided?

Therefore, we have recommended to HCFA the institution of a prior authorization, prepayment process. The carrier then could deny or authorize the transportation before any costs are incurred by the provider or the program. This will give the control of determining medical necessity to the carrier, saving Medicare money by cutting down on inappropriate transports.

We believe that the inspector general's own data bears out the wisdom of our recommendation. A review of the Medicare payment data reveals that Nationwide Insurance Co., an Ohio Medicare carrier, achieved program savings by cutting down on inappropriate payments for ambulance service after a prior authorization program was implemented.

We have other recommendations in our written testimony.

Before I leave this subject, I would like to briefly respond to the inspector general's recommendations to put dialysis transportation out to bid. While we find this idea intriguing, we believe that the inspector general has vastly overestimated the potential savings to be realized. We believe that the bids for the service will come in at or near the rates that are now being paid by Medicare because Medicare already pays a rate that is well below the provider's usual and customary charge. Thus we believe that significant savings from a competitive bid system just will not be realized.

ADVANCED LIFE SUPPORT

Now, let me turn to the subject of payment for advanced life support services, [ALS]. Over a decade ago, the role of the ambulance provider in the health care system was to respond to the patient in need, then transport the patient as quickly as possible to a qualified medical facility, usually a hospital. We are in a new era of emergency medical care. We strive to get the highest quality of

care to the patient as quickly as possible. We treat and stabilize the patient at the scene, communicate with a qualified hospital physician about the patient's condition, then transport, once the patient is stabilized, to the nearest appropriate medical facility. This modality of care is advanced life support.

The inspector general has reported that Medicare expenditures for ALS services have experienced tremendous growth and has recommended that HCFA stop paying ALS rates for a patient that does not fully utilize ALS services. This recommendation appears to be logical. Unfortunately, it is just not that simple.

Let us use a classic example. A 911 emergency call is received and the caller reports an excruciating abdominal pain. In an all-ALS system, an ambulance would immediately be dispatched. In a two-tiered system, which includes advanced life support and basic life support, if the choice was to send a BLS unit and the patient was actually having a heart attack, precious time would have been wasted and a life may be lost unnecessarily. I might add it is in this arena where we get the 911 calls where the dispatcher is attempting to practice medicine over the phone, as occurs frequently in Dallas and other cities.

In our judgment, the growth of all-ALS systems are better for patient care and the communities they serve.

Many local governments developed standards requiring ALS services for the citizens. Research studies evaluating this development have proven that patient mortality is reduced in all-ALS systems and that they provide better, more efficient care than two-tiered ALS/BLS systems. These studies are discussed in detail in our written remarks.

Coincidentally with this evolution in the industry, HCFA's payment policy was changed to allow for separate reimbursement for ALS services. In its study the inspector general took a snapshot of the industry from 1986 to 1989 when ALS systems grew the most. Therefore, it should come as no surprise that Medicare expenditures for those services also increased.

However, if you look at the more recent ALS reimbursement picture, you will see an encouraging trend. Based on the data our association obtained from HCFA, we find that during the 1992–93 period, the increase in cost per trip for ALS dropped to 5 percent, less than one-half the average growth from 1987 to 1993.

While Medicare expenditures for ALS services have risen dramatically over the past 6 years or so, a major contributing factor has been that EMS systems were evolving over that same period, in part due to the response to mandates from local governments, putting more ALS units out on the street and saving more lives. Now this evolution is nearing its conclusion. The expenditures are slowing appropriately.

However, a caution. There are two factors that will most likely contribute to a future significant growth in ALS expenditures. First, an aging population will increase the demand for our services. Second, there is an increasing number of providers who have never charged fees for their services before. I am speaking specifically about municipal and volunteer fire departments and ambulance corps.

In the area of ALS reimbursement, our recommendations are simple. The rise in ALS spending can be attributed in large part to the evolution of the EMS system design, and the systems are now beginning to reach maturity, pay dividends to our citizens in the form of vastly improved services and chances for survival, quality of life for the sick and injured. Therefore, we do not believe that Medicare needs to institute any drastic new changes to ALS reimbursement for ambulance providers.

In this light, we urge HCFA to continue coverage for ALS on 911-generated emergency calls. However, in those cases where ambulance service is needed for a nonemergency, prescheduled basis where the patient's condition is known in advance, we would not oppose restricting coverage for advanced life support services to cases where the patient's actual condition warrants this level of care. We will continue to work with HCFA to implement quickly our recommendations.

PREPARED STATEMENT

To conclude, any attempt to save Medicare dollars must be tempered with the understanding that the Federal Government is only a part, albeit a vital part, of the funding of this important service system. A precipitous act could seriously jeopardize the health and safety of all Americans.

I wish to thank you for the opportunity to testify and I will try to answer any of your questions.

[The statement follows:]

STATEMENT OF MARTIN YENAWINE

Good morning Mr. Chairman and Members of the Committee. My name is Martin Yenawine and I am President of the America Ambulance Association. I am accompanied by Joseph Paolella, Chairman of the Association's Government Affairs Committee.

The America Ambulance Association appreciates the opportunity to testify on the issue of Medicare reimbursement for ambulance services. The is the national trade association representing businesses who provide fee-for-service ground ambulance transportation. Our association primarily represents all forms of private providers, but also includes public utility models, volunteer ambulance corps, hospital-based ambulance providers and government-owned and operated services.

Mr. Chairman, we understand that the purpose of today's hearing is to examine the findings of the Inspector General of the Department of Health and Human Services in the areas of Medicare reimbursement for dialysis and for advanced life support services. We are prepared to address both areas and again appreciate the opportunity to respond to the issues raised in the reports.

I would like to speak first regarding the Inspector General's reports on dialysis services. The IG has raised concerns about the incidence of fraud and abuse with dialysis reimbursement. I would like to say a few words about the issue of fraud. Where it exists, we fully support efforts to ferret out and prosecute the wrong doers. Our Association abhors willful abuse of the Medicare system. In fact we go to great lengths to educate our Members about the complex rules governing this area—through published articles, notices to the Membership, and through quarterly educational seminars we hold in different locations around the country.

We have also met with the IG's office on numerous occasions giving them our recommendations for eliminating fraud and abuse in this area. Unfortunately, because this service has may unique characteristics it is quite costly—on average end stage renal disease (ESRD) patients require six transports a week (three treatments), which results in per patient costs in excess of $30,000 annually. As a result of this exceptionally high demand and cost for service, a few bad providers perpetrating fraud in this area has resulted in significant dollars lost to Medicare. To repeat, the America Ambulance Association is fully supportive of efforts to eliminate fraud in

this area and we will continue to work with HCFA and the IG to see this accomplished.

According to the HHS Inspector General's report entitled Medical Necessity, 70 percent of dialysis-related claims across 16 Carriers with the highest allowances did not meet Medicare's coverage requirements for medical necessity. While we can neither confirm nor deny this figure since we are unable to review the data the IG used, we agree that may claims paid by Medicare do not meet the medical necessity criteria for coverage. It is our firm belief, however, that this is not due to rampant fraud in our industry. Rather, we believe a significant part of the problem stems largely from the confusing and often conflicting rules set out by HCFA which creates a "gray area" regarding covered service guidelines. This gray area results in substantially different opinions about the patient's need for ambulance service among payers (i.e. Medicare), institutional providers (i.e. dialysis centers), and transport providers (i.e. ambulance companies).

I'd like to elaborate on this gray area surrounding the "medical necessity" issue and explain why this continues to be a source of confusion and inappropriate billings, and which, as a result, contributes to the growth in Medicare expenditures in the dialysis area. I'd like to start by providing a real life example for you so that you understand what happens.

The dialysis facility calls to schedule transportation by ambulance (as is usual, three times per week) for a patient whose condition they have watched deteriorate over time. Though the patient has "good days" and "bad days" it is charted that the patient experiences an increasing number of complications during treatment. The facility, which cares for the patient's needs, orders the ambulance based on the complications they have witnessed as well as the patient's general decline in health. Often the progression of this disease results in the patient having more than one established illness. The facility wants the safest mode of transportation for this generally unstable patient. The ambulance service must rely on the integrity of the information provided by, in this case, the nurses acting on behalf of the physicians at the facility.

The crew documents the patient's condition on every trip. A patient can appear to be stable when going to dialysis but the complications one can suffer during dialysis are many (e.g. nausea, vomiting, hypotension, weakness, dizziness, TIAs, lethargy and disrythmias). This can result in a completely changed condition when the patient leaves the treatment facility, and often does. On the other hand, a patient can be quite ill prior to dialysis because the patient's blood is full of toxins but after dialysis the patient can be in an improved condition.

We determine in good faith that the condition of the patient warrants transportation by ambulance based on the information we have at the time. We submit this information on a claim to the Carrier for payment. Several outcomes can result. Sometimes the Carrier reviews it and makes a determination that the claim should be paid. Other times claims are denied, then paid after a later review. Or, it is possible that after a detailed post-payment review, which includes a review of information about the patient we did not have access to, such as more complete records from the nursing home or dialysis facility, coverage could be denied and the provider required to reimburse the Carrier. We believe that the need to judge whether a patient's condition meets all the medical necessity requirements for Medicare coverage should be judged on an evaluation of all the information pertaining to the patient's condition, not simply a particular trip report to or from dialysis. And this judgment should be made by Medicare before ambulance service is provided to the patient.

Consequently, the American Ambulance Association has been working with HCFA to address these problems. We offer the same recommendations to the Committee as we have made to HCFA. Specifically, we recommend that HCFA institute a system of prior authorization for ESRD patient transport. Under such a system, the ambulance provider would be required to provide documentation from the dialysis facility, the treating physician and any other relevant parties that would assist the Carrier in determining if an ambulance is warranted. In this way, the Carrier could deny coverage or authorize the appropriate level of transport at the initial stages. This will give control of determining medical necessity to the Carrier.

We believe this recommendation is borne out by the IG's own data. In Appendix C of their most recent report on ESRD, the IG reports that in 1988, Nationwide Insurance Company in Ohio had 151 beneficiaries whose claims totaled more than $10,000 for ESRD ambulance transportation. This was more than any other jurisdiction in the nation. Concerned about the significant cost of transporting these patients, the Carrier determined that a more detailed review process was needed before a payment of claims would be made. Consequently, the Carrier working with the ambulance providers developed a program for prior authorization. The program achieved positive results. By 1991, the same Carrier had fallen to number six in

terms of overall number of beneficiaries with claims over $10,000. In comparison, the Carrier for down state New York experienced a nearly fourfold increase in the same period, and nearby Pennsylvania more than tripled. The bottom line here is we believe prior authorization will reduce overall Medicare expenditures by eliminating inappropriate transport. Similar systems of prior authorization have worked successfully in Medicaid programs administered by the states.

Another area of confusion leading to overpayments involves the origin and destination requirements. Often, coverage is not extended if the transportation is to a free standing dialysis facility that is not on or adjacent to a hospital, which is often difficult to discern. This leads to confusion on the part of the ambulance provider since they do not know if the facility meets the requirements. Thus, the ambulance provider submits the claim leaving it up to the Carrier to decide if the destination requirements are met. We would suggest that ambulance services be covered to any and all appropriate dialysis treatment facilities. In fact, this could save Medicare money in the long run since ambulance providers could then transport to the nearest appropriate facility, not the only facility approved by the Carrier, which might be twice as far away. And unfortunately this happens.

Finally, we would suggest that the Carriers be required to develop a medical necessity and payment system based on patient condition codes as opposed to patient diagnosis codes as is current practice. As pre-hospital care providers, we do not make diagnosis determinations of a patient's medical problem. Our treatment is based on the patient's condition at the time of need. A listing of approved conditions would also substantially reduce inappropriate payments.

We would also like to briefly respond to some of the IG's recommendations. One recommendation made by the IG is to put ESRD transport out to bid. While we find this idea intriguing, we believe that the IG has vastly overestimated the potential savings to be realized. We believe this for two important reasons. First, the entity which becomes responsible for directing the bidding—whether it is the dialysis facility or the Carrier—will be required to institute a whole new administrative system and therefore incur the additional costs associated with that new system. Secondly, and perhaps more importantly, we do not believe that bids for this service will come in below those rates now being paid by Medicare. Currently, Medicare allows a rate that is often substantially below a provider's customary charge, and then pays only 80 percent of that amount. Since most beneficiaries live on a fixed income and lack the ability to pay the remaining co-insurance of 20 percent which adds to an ambulance provider's uncompensated care costs. Under a bidding system then, it is quite unlikely that bids will come in below the amount currently paid by Medicare since this would result in a reimbursement rate substantially below the cost of providing the service. Thus, we believe the savings from a competitively bid system are somewhat suspect.

ALS

Now let me turn to the subject of payment for advanced life support—or ALS as we call it. Over a decade ago, the role of the ambulance provider in the health care system was to respond to a patient in need, then transport that patient as quickly as possible, to a qualified medical facility, usually a hospital. We are in a new era in health care delivery, in part due to efforts by the federal government. Emergency medical service systems have evolved to the point where, in emergencies, we strive to get the highest quality of care to a patient in need as quickly as possible, treat and stabilize the patient at the scene by communicating with a qualified hospital physician about the patient's condition, and then transport to the nearest appropriate medical facility. In general, this means that high quality EMS systems must utilize advanced life support ambulances, as opposed to basic life support—or BLS—units.

The IG has reported that Medicare expenditures for ALS services have experienced tremendous growth. Having reviewed the data from HCFA on these expenditures, the IG makes what appears to be a fairly straight forward recommendation—stop paying ALS rates for a patient that did not fully utilize ALS services. Unfortunately, it's just not that simple.

Let me explain. Again, you are an ambulance provider and you get a 911 emergency call. The caller reports experiencing chest pain. In an all-ALS system, you immediately dispatch an ALS ambulance. In a system required to have both ALS and BLS units, the dispatcher needs additional information to determine which is the appropriate ambulance to send. This information is difficult to obtain from the caller because they are unlikely to have the medical skills needed to further judge the patient's condition. The dispatcher often chooses to send an ALS unit so as not to risk further deterioration of the patient's condition. If the choice was to send a BLS unit

and an ALS unit was needed, precious time is lost in the patient's fight for survival. In an all-ALS system there is no need for the dispatcher to triage calls, thus eliminating the possibility that he or she will dispatch an inappropriate level of care.

Recent studies have shown that an all-ALS system provides better, more efficient care than a two tiered ALS/BLS system and are thus a better value to the community served. In a study conducted in 1992 in Kansas City, researchers examined an all-ALS system focusing on unexpected ALS procedures needed on non-emergency calls coming through the 911 system. In 309 cases, the patient's condition was initially determined to be non-emergent, but subsequent information led the dispatcher to upgrade the patient to emergent condition while an ambulance was en route to the patient. The study showed that nearly half (46.6 percent) of these calls required the use of one or more ALS procedures. In addition, the study reports that 12 percent of the patients deemed by the dispatcher to be non-emergent actually required ALS intervention. This study supports the use of an all-ALS system. A second study in Richmond which concluded that the cost differential between a single-tiered and dual-tiered system was minimal is further evidence that an all-ALS system works. (Unexpected ALS Procedures on Non-Emergency Ambulance Calls: The Value of a Single-Tier System, Wilson, Gratton, Overton & Watson, 1992. Pre-hospital and Disaster Medicine, 7,4, 380–382; Pre-hospital Advanced Cardiac Life Support: Evaluation of a Decade of Experience, Crampton, 1980. American Journal of Public Health, 83(7), 955–959).

Generally, EMS system design has evolved in the past ten years with an eye toward providing higher quality, more efficient service to communities around the country. In the late '70's and early '80's, numerous state legislatures enacted laws giving local governments the responsibility for guaranteeing their citizens high quality EMS service, much as they have responsibility for police and fire services. Many local governments developed standards requiring ALS service for their citizens. Contracts were awarded to providers who met the standards. Medical evidence bears out the wisdom of these decisions. Recent studies have shown reduced patient morbidity and mortality, in particular in cardiac arrest and trauma cases, in all-ALS systems.

A six year study of out of hospital cardiac arrest conducted in Pennsylvania found that early ALS intervention is crucial in the determination of patient outcomes. Regarding trauma, a 1993 study in New York concluded that patients transported by ALS units had significantly better outcomes than those transported on BLS units. Studies in North and South Carolina are in substantial agreement regarding the positive value of ALS in trauma related injuries. In fact, in 1990 the editors of Annals of Emergency Magazine went so far as to call ALS a moral imperative. (Out-of-Hospital Cardiac Arrest: A Six Year Experience in a Suburban-Rural Setting, Eitel, Walton, Guerci, Hess & Sabulsky, 1988. Annals of Emergency Medicine, 17(8), 75–79; Dual Response Runs in Pre-Hospital Trauma Care, Murphy, Cayten, Stahl & Glasser, 1993. The Journal of Trauma, 35(3), 356–362; The Need for ALS in Urban and Suburban EMS Systems (editorial), Ornato, Racht, Fitch & Berry, 1990. Annals of Emergency Medicine, 19, 12, 1469–1470).

These types of results, combined with a recognition within the industry of the efficiencies of an all-ALS system design, resulted in a virtual explosion in ALS service in the early and mid '80s that is only now beginning to taper off. Coincidental with this evolution in the industry, HCFA payment policy was changed to allow for separate reimbursement for all-ALS systems. In its study, the IG took a snapshot of the industry from 1987 to 1993, as more and more systems moved from BLS systems to ALS systems. Therefore, it should come as no surprise that Medicare expenditures for those services also rose.

But beyond that, we believe that if you look at the total picture you will see an encouraging trend. As the evolution of our industry from BLS to ALS systems has neared completion, so too has the growth in Medicare expenditures for ALS. From 1987 to 1993, when the evolution was peaking, the number of ALS transports grew by over 300 percent and ALS expenditures grew at an average rate of 77 percent annually. However, from 1992 to 1993, when the number of ALS transports grew by just 14 percent, the growth in ALS expenditures dropped to 20 percent.

Perhaps even more importantly, during the 1992–1993 period, the actual growth in cost per trip for ALS dropped to 5 percent, less than half the annual average from 1987 to 1993. Incidentally, this most current growth rate is well below the overall growth rate for the health care industry at large.

What I am trying to explain with these numbers is that, while Medicare expenditures for ALS services have risen dramatically in the past six or so years, a major contributing factor has been that EMS system design was evolving over that same period—in part in response to mandates from local governments—putting more ALS units out on the street and saving more lives. Now that this evolution is nearing

its conclusion, the expenditures are slowing appropriately. In addition, we want to note two other factors which are contributing to the increase in ALS expenditures.

First, we are simply seeing the results of the aging population. Medicare beneficiaries are the heaviest users of ambulance services, and when the baby boomers enter the Medicare system, we can not expect anything but growth in the use of our services. And secondly, we are seeing an increasing number of claims filed by providers who have never before charged fees for their services. I am speaking specifically about municipal fire departments and other volunteer ambulance corps. There are a couple of reasons these services are beginning to bill Medicare for the first time. Fire departments, which are supported by tax dollars, have been faced with the same type of cutbacks which are facing all municipal services. Therefore they have been forced to identify new revenue sources and are now billing the Medicare program for their services. For the volunteer ambulance corps, the problem is personnel costs. As more and more families rely on dual incomes, volunteer services have found it harder and harder to recruit volunteers. Therefore, they have had to hire trained personnel, incurring new costs, and have in turn been forced to charge fees for their services. It is unclear what effect this developing trend of fire departments and volunteer ambulance corps seeking Medicare reimbursement will have on future growth.

In the area of ALS reimbursement, our recommendations are simple. Since the rise in ALS spending can be attributed in large part to the evolution of EMS system design, and since this evolution is drawing to a close, we do not believe that Medicare needs to institute any drastic new controls on ALS reimbursement for ambulance providers. In light of this, we urge that HCFA continue to cover ALS for all 911-generated emergency calls. However, in those cases where ambulance service is needed on a non-emergency, pre-scheduled basis where the patient's condition is known in advance, we would not oppose restricting coverage for advanced life support services to cases where the patient's actual condition warrants this level of care.

To conclude, we believe that for Medicare to change the reimbursement rules now that ALS systems are fully functional would jeopardize the EMS infrastructure that state and local governments deemed necessary for the health and safety of their citizens. It would seriously challenge what those local entities have been building over the past decade. Perhaps even more seriously though, the federal government could unwittingly endanger the standard of care provided to many communities throughout the U.S. by denying ALS reimbursement in those areas deemed by local authorities to benefit from these advanced EMS services.

One final thought on ALS. We believe that to get a complete perspective on the utility of ALS and its place in today's EMS systems, you need to get comments from the National Association of State EMS Directors as well as the physician community, in particular the American College of Emergency Physicians and the National Association of Emergency Medical Physicians. These groups have been actively involved in EMS system design, oversight and research.

Thank you again for the opportunity to testify. I would be happy to answer any questions you may have.

Senator HARKIN. Thank you very much, Mr. Yenawine, for a straightforward statement.

Basically what you are saying is that you had this tremendous growth in EMS services but it is leveling off now. Is that what you are kind of saying?

Mr. YENAWINE. Yes; I think the development of ALS systems—there was a period of time where they grew very dramatically. I think that most systems now have reached that sophisticated level.

Senator HARKIN. In terms of prior authorization, I think we had testimony that 50 percent now prescreen. I asked the question to Ms. Buto why is that not extended, why does she not just put a mandate out there that everyone prescreen.

Mr. YENAWINE. Well, we would concur with that. I think there are two issues here, though, Senator, that I think are coming into play. One is a preauthorization, which means before the patient is moved, we determine his eligibility for this kind of benefit, or prescreening, which is done essentially in the office. It is a preauthorization, or a prepayment screen looks at a patient's condi-

tion, at least the forms and those kinds of things. A preauthorization is a real act to say this person qualifies.

So, I think there are two separate directions. I do not know if I am being clear, but there are two different procedures. We are asking that all patients that are potentially eligible for dialysis be preauthorized, the determination for their benefit be preauthorized. This would save us a tremendous amount of problem.

Senator HARKIN. Then how would the repayment rate—it would be made at the BLS rate rather than ALS rate. Right?

Mr. YENAWINE. It would determine on the patient's condition.

Mr. PAOLELLA. Senator, I think we are mixing the issues. Most dialysis patients do not get advanced life support services. They get basic life support services.

Senator HARKIN. That is true.

Mr. PAOLELLA. The reimbursement would be only for those that are inappropriately paid.

But this prior authorization process, the way we envision is the onus of responsibility is on the ambulance provider, dialysis treatment facility, and let us say a convalescent home where a patient may be residing. We can gather that data. We can submit that data to the carriers and the carriers can say, OK, this patient does have a medical need for an ambulance and authorize payment where in fact it is needed for a period of time, whether that is 60 days or 90 days. Subsequent to that, all those parties that are involved in the treatment for the patient and the transportation will be constantly resubmitting data to the carrier for an extended period of time of approval.

It has worked in Ohio. I was happy to hear that HCFA reported that it is being adopted by other carriers throughout the country, and we think it could be adopted uniformly throughout the country and we would support it.

Senator HARKIN. I think I understand. I am not certain that I do completely. Well, they said 70 percent—I do not know what the figure is now—of ESRD patients do not meet the guidelines and in fact do not need really ambulance service. They could be taken in a car or something like that. Is that part of what you are getting at, how do we ferret out those that do not need the ambulance service?

Mr. PAOLELLA. Yes; I think clearly a prior authorization process. Control would be given to the carrier and the carrier would say this patient does not warrant the need of an ambulance.

Senator HARKIN. Well, that seems to make good sense to me. If they are in an emergency, obviously they call 911 and they get an emergency anyway.

Mr. PAOLELLA. Well, there are administrative costs. We recognize that and HCFA testified in terms of the limited dollars that they have for these types of programs. We are sensitive to that. But in terms of the dollars that are inappropriately paid, we feel it is a worthwhile investment.

It is very difficult on a provider since we described in our testimony this gray area. These people are very, very sick. They have complicating illnesses besides kidney failure. They could have heart related problems. They can have respiratory problems. The coverage guidelines clearly continue to be unclear if I can say it that

way. This prior authorization process would eliminate all of that because they would set certain standards that would have to be met, and if those standards are not met based on the data that is submitted, trips will not be authorized for payment.

Senator HARKIN. In areas where local ordinances—you heard me question—require ALS services, even when they are not medically necessary, would you support payment at the lower BLS rates?

Mr. YENAWINE. I do not think from an association point of view we are prepared to say that today because it is complicated. When you get a 911 call, no one knows the condition of the patient until you arrive at the scene. The research currently is showing that having an all-ALS system respond is in fact providing better response times, better clinical quality to the patient, and in some systems there is even some evidence that it may even be more cost efficient because you can deploy your resources universally as opposed to selectively, a BLS unit or an ALS unit. It does not matter. You just send the closest available ambulance to that call. There is some evidence to show that that system is even more cost effective.

So, the question of a 911 call is a little more complicated than the one that says we know the patient's condition. It is a BLS condition. For heaven's sakes, yes, we agree. Charge a BLS rate for that service.

Senator HARKIN. If a Medicare recipient is transported by ambulance to a medical facility, it would seem to me—maybe there is something I do not understand, but there are all these forms that are filled out anyway. They can just say what services did you receive in your ambulance. If they just sat there and got a ride, then they should be reimbursed at a much lower rate than if in fact they got heart defibrillation and everything else during the ambulance ride. Why could that not be done?

Mr. PAOLELLA. The vast majority of calls that come in, Senator, to a 911 system are not inappropriate calls. The patient is experiencing some kind of pain, some kind of illness, and they feel they need medical care. That information comes through our dispatch center. We have to make a judgment at that period of time, what is the best possible treatment and what is the best response based on the information that we are told. When we arrive at the scene, the treatment procedures that we operate under are in fact controlled by the medical facilities that we do business with.

I operate in the city of New Haven. The medical director for the Yale New Haven Hospital writes the protocols upon which we treat those patients. Sometimes communications occur between the vehicle, the ambulance attendant, the paramedic from the vehicle to the hospital where we are relaying this information to the hospital stating what the patient's conditions are. Operating protocols take control at that point. In other words, if you visually see this particular condition, you will do this. So, we treat based on conditions. We do not make diagnoses in the field. That is not our job. It never has been even with the advent of advanced life support care, critical care transport. We do not make those diagnoses. We are not licensed to do that. So, we treat on certain conditions.

Studies have shown that when you have an all-ALS system, yes, there are some times when after the fact it has been proven that

the patient did not need advanced life support care, could have gone by BLS, but when you take a look at the total system costs, it has been shown that it is more efficient, and in fact saves lives, reduces mortality, when you have an all-ALS system.

Senator HARKIN. Do you have any data that would support improved outcomes for patients being served with ALS as compared to BLS ambulances?

Mr. PAOLELLA. Yes; there have been studies that have been done within the last 5 years. They have been done in Kansas City. They have been done in Richmond. They have been done in the States of South Carolina, North Carolina. Currently what is being done by the University of Maryland is a compilation of all the studies that have been published over the last decade and to evaluate what those studies in fact report.

Senator HARKIN. So, you disagree with HCFA then. The HCFA study on ambulance services shows that there is little evidence that ALS ambulances make a difference in patient care compared to the medical effectiveness of BLS services.

Mr. YENAWINE. Yes; we do.

Senator HARKIN. Could you submit some evidence for the record so we can take a look at that then?

Mr. YENAWINE. I believe that we put some of that in our written materials. We referenced the studies in our written materials and we can provide those studies for you, sir.

Senator HARKIN. I would appreciate it because I would like to get HCFA back up and find out what they are talking about and where they got their information.

Mr. PAOLELLA. Senator, can I add one more point on this issue of the mandate? These mandates are not something that providers establish for themselves. The way an EMS system develops, there is a significant amount of input from a whole range of sources. Obviously one component is the ambulance provider community, but you are talking about physicians, hospital administrators, other third party payers. You are talking about regulators, State health directors, EMS directors that look at these systems, design them, and then say this is the standard that we want to be met. Then the provider has to meet the standards if in fact you are going to provide service in that area.

So, whether or not the Federal Government should be paying for a service that is mandated by a local community or a countywide area or a State regulatory matter is something that needs review, but we want to impress upon you that that is not something that the ambulance provider community is doing on their own.

Senator HARKIN. No; I understand that.

Do you have anything else for the record, Mr. Yenawine?

Mr. YENAWINE. Senator, I just wanted to close maybe with this thought, that the issue of fraud and abuse is something that the American Ambulance Association has been tremendously concerned about. Most ambulance services that I have the great fortune of knowing and the owners that I have gotten to know are small business people who work diligently to create a public trust in the community that they serve. That public trust is immediately dashed through sloppy billing practices or willful fraud because assuredly it is a front page story. Now, the people that I know have their

names, their houses, their wives, and husbands on an enormous number of back loans to support these small businesses that do this work and do not willfully or want to abuse or create any kind of semblance of fraud.

It is a very small number of ambulance services in this country. I think that they can be identified, particularly in dialysis, very quickly. A study by the inspector general said that there were 88 firms who picked up, if you will, 60 percent of the revenues in dialysis. So, you can get your hands around it fairly fast and determine whether those firms are doing work appropriately or not.

I ask you to consider that the issue of fraud and abuse is done by some people who are either sloppy, careless, or just downright rotten. I feel badly about that, that they are in our industry, and we will do everything we can to help you ferret it out.

Senator HARKIN. I appreciate that very much, Mr. Yenawine. You are a very eloquent spokesman for your industry. It is again a good industry by and large. As you say, in anything there is always a few rotten apples in every barrel.

The purpose of this hearing is not only just to get HCFA moving and to change the way we reimburse and to get a handle on this, get the slope of that line coming down, cut down on some of the discrepancies, and save some of this money. We are talking about one-half billion dollars. You are a taxpayer too and ambulance owners out there are all taxpayers too.

Mr. YENAWINE. You are right, sir. We are all for it.

Senator HARKIN. So, we have got to cut this thing down. So, that is one purpose.

The other is to again ask your association, ask you and through you your association, to do whatever you can voluntarily and through whatever means you have as an association and through the ambulance companies that are operating in good faith that do provide a good service, are not ripping off the taxpayers to get them to help monitor and help us clean this situation up. We look forward to working with you on that.

Mr. YENAWINE. Sir, you have our assurances that we will be with you.

CONCLUSION OF HEARING

Senator HARKIN. Thank you very much for being here.

I want to thank all of the witnesses for appearing today.

The subcommittee will stand in recess subject to the call of the Chair.

[Whereupon, at 11:23 a.m., Friday, December 16, the hearing was concluded and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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